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A SANATORIUM FOR INDIGENT CONSUMPTIVES.

By L. Bazet, M. D.,

Read before San Francisco Board of Health, October 19th, 1900.

The establishment of a sanatorium for consumptives is an easy matter. In France, Switzerland and Germany, satisfactory results have been obtained by adding, to the ordinary equipment of a hospital, a few tents, open on one side, reclining chairs and blankets. Everything depends upon the attending physician, but to obtain a decided result, a special building should be constructed. Let it be understood that we are considering here only poor patients, for whom alone, it is possible to plan on such a large scale. It is preferable to treat paying patients in small sanatoria established in the residence of the physician (Legendre).

First and foremost, three standard requirements are necessary, relative to the quality: 1. Of the air; its purity and its shelter from cold and moist winds. 2. Of the ground; dryness and freedom from organic matter. 3. Of the water; clearness and coolness. The site selected should be in the neighborhood of a forest of certain species of tree, and on gently sloping ground. As a rule, sanatoria consist of single main buildings, the accessory service being separate. The system of isolated pavilions, although more expensive, and difficult to superintend, is preferable from a hygienic standpoint. A sanatorium should be provided with accommodations for 100 to 150 patients, so disposed that a medical director, assisted by an attending physician, could easily superintend and direct the whole service. The buildings, not more than two stories high, should not have wings, because these cast shadows on the facades, thus depriving them of the full benefit of the sun. The most important part of the sanatorium is a veranda, where the patients, stretched out on reclining chairs, can enjoy the open air and the sun. This veranda, annexed to the main building, to be duplicated within by another gallery, equally wide, but better protected against inclement weather. The rooms should accommodate from two to four beds, and possibly six. The air space should be at least 40 c. m. per bed. Walls painted so that they may be easily washed. Floors parafined or covered with linoleum. All corners rounded. Windows, wide, and provided with movable imposts in the upper part and screened with blinds consisting of a thick slab of wood. The heating should be automatic by hot vapor, hot water or any method which would contain no dust. The patients should occupy their rooms only at night, remaining on the veranda as much as possible; their meals, which should be well served, should be taken in a special apartment,—a comfortable dining hall. A short gallery should connect the dining hall with the kitchen, situated in an isolated pavilion. There should also be provided: 1. A residence for the physician. 2. Accommodations for the assistants. 3. A laundry, machine-shop, and a building for the disinfecting and stertilizing apparatus. 4. Water reservoir, with its filter. 5. A morgue. 6.

Stables and coach-house. 7. Cow-house. All these buildings should be concealed by trees and shrubbery, pleasing to the eye. If room be lacking, it might, suffice to install the laundry, the machine shops, the kitchen and its dependencies, the dining room of the personnel, etc., in the basement of the main building. Adjoining the veranda, should be located the doctor's office, a large dressing room, a washstand, a library and a reception room. The physician should be provided with a well-equipped laboratory, which would enable him to use to advantage, the observations that he has accumulated from the patients under his charge. The service, for the most part, may be common to both men and women, but their rooms should be in separate buildings. While it is comparatively easy to establish and maintain an adjunct to a hospital, to serve as a substitute for a sanatorium, the establishment of a complete and well equipped sanatorium for indigent consumptives is a colossal task. Hence, you will understand why I dwell upon results—results which are clear to all thinking minds that consider a human life as so much active capital, worthy of being cared for, even at considerable expense. I append hereto, a detailed plan of the sanatorium of Angicourt, near Paris, which, if turned into account by an architect, would give satisfactory results. The plan provides for a magnificent establishment, which, although beginning on a small scale, gradually assumes imposing proportions.

PLAN OF THE ANGICOURT SANATORIUM.

1.—Part actually constructed right wing, the other part will shortly be constructed, the funds are voted. 2.—Administration Building. 3.—Kitchen. 4.—Dining-room. 5.—Machines. 6.—Laundry. 7.—Morgue. 8.—Dairy. 9.—Stable. 10.—Reservoir. 11.—Dryer. 12.—Spring. 13.—Medical Superintendent. 14.—Agency. 15.—Filtering Reservoir. 16—Absorbing Well.

APPROXIMATE COST.

It is almost impossible to state definitely the exact cost; we can arrive at it only by comparison. It is estimated that each bed in the sanatorium of Angicourt costs $1,800, that is, 200 patients require $360,000. This sanatorium is the latest one established, and the most expensive. The sanatorium of Hauteville, near Lyons, costs $160,000 for 110 patients, that is $1,400 per bed. At the Bern Hospital of Heiligen-Schwendi, each bed costs but $1,200; that of the sanatorium of Davos-Dorfi, near Bale, costs $1,340. The last mentioned sanatorium is perhaps the best equipped, and contains about 78 beds. It is necessary to consider, not only the cost of equipment, but also that of maintenance; the latter is influenced by the former, since it pays the interest of the former. Thus, at Angicourt, the daily cost is 64 cents per patient; at Heiligen-Schwendi, 38 cents, all expenses included; at Davos-Dorfli, the cost is $1.00, 60 cents and 40 cents, according to the means of the patient. The principal items of expense are: food, which must be particularly rich and carefully prepared, heating, lighting, washing, repairs, and finally, the personnel, which varies greatly. It is estimated that at Davos-Dorfli, for 78 beds, there are: 1 medical director, 1 assistant physician, 1 matron, 1 nurse, 11 servants. Each patient must remain in the sanatorium at least three months. But that is not all, it must be well understood that admission to the sanatorium will be given to a head of a family, but slightly affected, since only such cases can be cured; that the patient in question will not be uneasy concerning his family, and that his health will afterwards permit him to support it. The cost of giving succor to a patient's family, greatly increases the expense incurred by the treatment. Let us remember that it is an economic advantage not to let a patient die, for then his family will be still greater burden to society. We will examine these expenses, and the results. Say that a workman, who has been cured, represents an important social gain, whose value we shall calculate later on. Let us show first, how many we can cure. Out of 100 workmen at Dannenfels, in all of whom the bacilli of Koch was shown in their expectorations; 21 were cured, that is, they left the sanatorium without bacilli in their expectoration, and labored one year without a relapse; 16 were so improved that they worked without interruption; 12 were improved, but ceased working occasionally; 4 were improved, but suffered relapses; 25 were either incurable, or died shortly after. These figures closely approximate those given by Dr. Gebhard of the Hanseatic Company at Oderberg. They represent the results of a second examination, that is, the result of an examination which took place sometime after the patients had left the sanatorium. Thirty-five per cent had full capacity for work, and ability to maintain it; 43 per cent had full capacity for work, but doubtful for the future; 17 per cent had partial capacity for work, light occupations; 5 per cent has absolute incapacity. The following are the results of the statistics of the sanatorium at Gorderndorff. They supplement the preceding by bearing upon patients who have remained at the sanatorium for three, and even four years, and are of interest because they confirm the above mentioned figures. Examination in 1900 of patients, who entered the sanatorium in 1895, gave the following results: 49.2 per cent were dead; 17.5 per cent showed partial or total incapacity for work; 33.3 per cent showed full capacity for work. That is to say, four years after being cured, one-third of the workmen had labored without interruption; an admirable result. Statistics are less favorable for patients of 1896: Fifty-five per cent died; 15.8 per cent were incapable of work; 28.2 per cent labored without interruption. During the next two years the figures show an improvement. Of the patients of 1897, 30.4 per cent died; 25.1 per cent were incapable of work; 44.5 per cent showed full capacity for work. Of the patients of 1898, 17.7 per cent died; 34.2 per cent were incapable of work; 48.1 per cent showed full capacity for work. Of the patients of 1899, 0.9 per cent died; 21.6 per cent were incapable of work; 14.6 per cent showed partial capacity for work; 62.9 per cent showed full capacity for work. But as only 23.2 per cent of the patients of 1899, were working before their admission to the sanatorium, there is an economic gain of 39 per cent at least, for I leave out of account, patients with an incomplete capacity for work. Finally, and worthy of remark, according to statistics, advanced cases of tuberculosis in the third degree, have been admitted to this sanatorium. If admission were limited to cases of the first degree, the results would be much better. For cases in the first period of tuberculosis: 94.5 per cent have full capacity for work; 5.5 per cent have incomplete capacity for work; .0 per cent died. For cases in the second period of tuberculosis 36.4 per cent showed full capacity for work; 9.1 per cent showed partial capacity; 4.5 per cent showed incapacity; .0 per cent died. The foregoing data, the most recent, and the most detailed that it is possible to obtain, certainly speak well for the establishment of a sanatorium for consumptives. The Department of Hygiene of the German Empire, furnishes the following data: If 12,000 persons, out of the 90,000, who die of consumption between the ages of 15 and 60, were treated at a sanatorium, and if 9,000 of these could continue their work uninterruptedly for a period of three years, it follows that, considering $125 as the average annual salary, the economic gain would be $125x9,000-$3,373,000. Deducting the cost of treatment, and the interest on the capital involved, the gain would still be $1,775,000. No statistics are obtainable for the State of California, but the statistics compiled by the Board of Health for the City and County of San Francisco, show the following: Deaths from tuberculosis, 1898-1899, 1,132; deaths from tuberculosis, 1899-1900, 1,212. If only 10 per cent of the average number of persons, who die of consumption in any one year in San Francisco (which average is shown by the above data to be 1,172), were treated at a sanatorium, and enabled to continue at work for a period of three years, the local economic gain would be 117 x 3 x $125 or $43,875. Estimating the cost of treatment and other expenses to be the same as in Germany, the net gain would be $23,075. Evidently, these figures are too relative, but Penzoldt, in his treatise on "Therapeutics" (June, 1898) finds them to be far below the actual truth. And that is true, for in our estimate, we have not taken into account an important factor; that every consumptive isolated in a sanatorium until he is cured, means a suppressed source of contagion, and hence, the preservation of 10, 20, 100 (who can say how many) patients of all classes and conditions of society. This is the balance-sheet and it shows a considerable surplus. The existence of numerous sanatoria, in active operation, proves that patients feel no repugnance towards entering them, which has been feared. Experience further demonstrates the groundlessness of another objection—that there is danger of contagion within the sanatorium itself. "No new cases ever declare themselves within the establishment." The system of spittoons is such as to prevent this.

RESOURCES.—To whom shall we apply in order to procure the necessary funds for the establishment and maintenance of such sanatoria? 1. The counties and the State should give the greater part, based on purely practical motives,—economy of lives, necessity for the relief of widows and orphans, and the protection of healthy citizens. 2. Philanthropic and Benevolent Societies. 3. Employers who desire to help skillful and efficient workmen. 4. Insurance companies against disease. A consumptive usually dies in less than two years, he can be cured in three months. 5. Insurance companies against invalidity and old age. These five elements of resource are borrowed from the report of Meyer at the last Congress of Berlin. Insurance against invalidity and old age, which figures here, is obligatory in Germany, and consequently the companies, being very wealthy, can do a great deal, even while working to their own advantage, to retard as much as possible, the period of invalidity initiated by consumption. Let us hope that the United States will imitate Germany in this matter. Before concluding I will give a few details concerning each of the elements of resource which I have cited. The sanatorium of Angicourt is the type of the sanatorium established by the county and State. The administration of Public Assistance, aided by the Board of Supervisors, called the Municipal Council of Paris, assumes entire control and defrays all expenses. The only fault the Parisians have to find with this institution is that it should have been in working operation ten years ago, whereas, it is not yet open. But with reference to relief afforded by the Government are we more expeditious in the United States than they are in France? I doubt it. Experience has taught me that the machinery of government kills all initiative, all responsibility and enthusiasm for the accomplishment of a noble and humane object. Let me cite, as an instance, my long and useless efforts to obtain a disinfecting station, whereby the mortality rate could be reduced from 23 per 1,000 to less than 20 per 1,000. A grave condition of affairs, to be seriously considered by those most interested—the people—who know that the most precious treasure entrusted to a government, is the care of the public health. Fortunately, we can still count upon the munificence of private individuals, and of philanthropic and benevolent societies, which have accomplished such wonders in Europe, as the institutions for consumptive children; the sanatoria for adults in France; the seven sanatoria in Switzerland, containing 366 beds; those of Germany; that of Molde, in Norway, etc. In all these cases, the counties have helped by subsidies sometimes of considerable magnitude, although it was entirely without relying on municipal or State aid that the initiative was taken by charitably inclined private individuals to put sanatoria into operation and thereafter they progressed rapidly. The sanatorium of Dannenfels, in the Grand Duchy of Baden, constructed by the "Soda and Aniline" factory of Ludwigshafen, is the type of a sanatorium supported by an employer. It was opened in 1893. We have already cited the number of cases, taking as authority, Dr. Westhoven's communication to the Berlin Congress. The Lubeck Hanseatic Insurance Company, the policies of which provide for indemnity for accidents and old age, has established the beautiful sanatorium of Oldenberg in the Harz. This company, evidently finding it profitable, expended $46,410 during the year 1897, for the relief of consumptives. The insurance Company of Railroad and Steamship Employees, of the Grand Duchy of Baden, at Mazell in the Black Forest, the Hanover Insurance Company at Konigsberg, and several others have also established sanatoria, but on a smaller scale. Very often, insurance companies subsidize private charitable enterprises, or advance the capital necessary, without charging interest, as at Albertsberg, where the Saxony Company exacts but 40 beds for its own use, in lieu of interest, or they may charge a merely nominal rate, e. g. one-half per cent charged by the Palatine Insurance Company at Spire. Remembering, however, that insurance is obligatory in Germany, the problem is somewhat changed. Moreover, the physicians of these insurance companies, after officially summoning the insured to frequent medical examination, oblige them to enter a sanatorium as soon as consumption manifests itself. Contagion being thereby so well guarded against in factories, the number of patients has diminished considerably. If the patient remains 15 days in the sanatorium, his family has a right to the whole sum of his insurance during the time he remains in the institution. Finally, the company, finds and gives an easy and healthful occupation to each workman, upon his leaving the sanatorium, as he is not strong enough to work in the factories. According to my mind, the first movement towards a sanatorium should spring from private initiative. It will be easy to point out to the municipal authorities, to the State, to employers and to insurance companies, the immense advantages which accrue from such an institution. The funds obtained by private sûbscription could be greatly increased by granting to the five elements mentioned, specified advantages, as the disposal of a certain number of beds in proportion to the sum subscribed; or, as in Switzerland, the distribution of shares which yield no interest, but are redeemable if the sanatorium should fail. If funds are to be raised by private subscription, it would be necessary to obtain the co-operation of eminent and honored men, scholars, philanthropists, etc., whose popularity and fame would be a guarantee of success. It was the Reverend Rion, who founded the "National Savings" for poor consumptives in Switzerland; the Lord Chancellor of the German Empire, who instituted a central committee, favorable to the establishment of a sanatorium; Prince Louis of Bavaria is at the head of a powerful society which furthers all such enterprises. I cite these instances as illustrating the success of appeals for popular aid when made by men in whom the people have unlimited confidence. San Francisco should follow this noble movement, and put into practice those ideas developed in Europe by private benevolent societies; the city should construct, on its own territory, a sanatorium for indigent consumptives. thereby assuring them hygienic treatment and cure. Henceforth, we must arm ourselves for the crusade by means of lectures, newspapers and pamphlets; we must rouse public sentiment; we must show that persons who aid the cause financially are conferring great benefit upon themselves; for tuberculosis, respecting neither rich or poor, is progressing alarmingly and is a constant menace to humanity. A tremendous effort must be made to struggle against and conquer it.

INCURABLE CONSUMPTIVES.—It must be understood that only those persons who are slightly attacked by the disease, may be admitted to the sanatorium, for only such cases can derive any benefit from the treatment. The question of incurable consumptives can be solved only by establishing a special asylum for incurables. All the objections made against such an asylum can be classed as sentimental, but they give way before the actual facts. The patients accept this asylum because they experience there comfort and peace; some improve so much that they still have hope of being cured. Such an asylum should be far removed from the city, and should employ, and even give slight remuneration to such of the patients as are capable of doing light work.

OXYCAMPHOR — A NEW CAMPHOR PREPARATION IN THE TREATMENT OF ASTHMA.

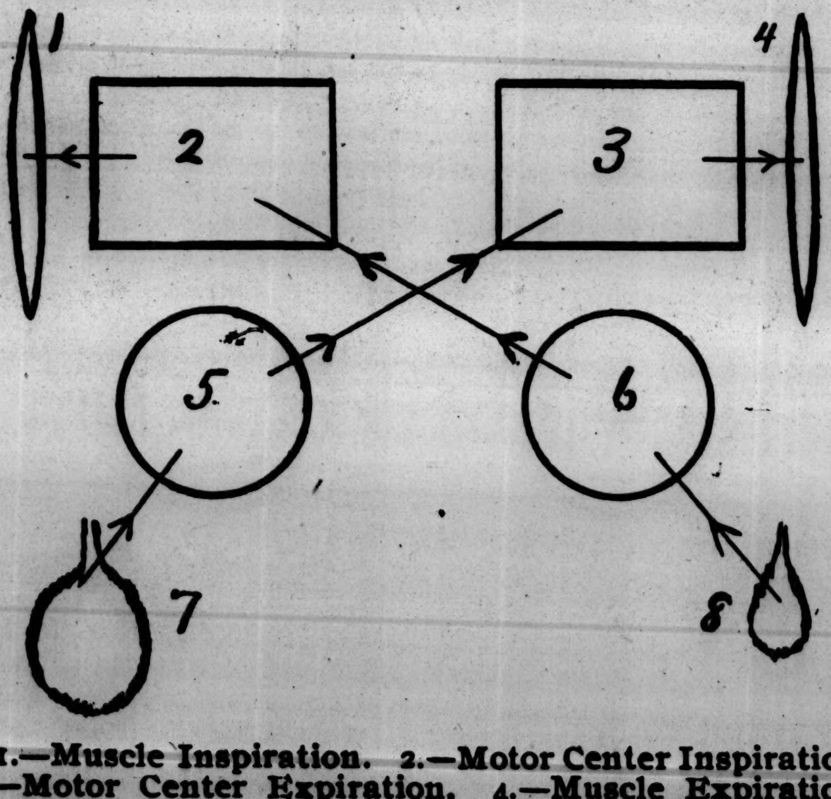
By J. O. Hirschfelder, M. D., Professor of Clinical Medicine, Cooper Medical College, San Francisco.

Read before the San Francisco Medico-Chirurgical Society, November 6, 1900.

In the course of a long series of chemical investigations of the substitution products of camphor Dr. Manasse, of Munich, sought for the soluble preparation, which should have the most potent camphor influence upon the animal organism. Among other derivatives he prepared an oxydized camphor, in which one of the hydrogen atoms of the camphor molecule, $C_8H_{14}\left\{\begin{matrix}CH^2\\CO\end{matrix}\right.$ was replaced by the hydroxyl molecule OH, giving rise to a preparation whose formula is $C_8H_{14}\left\{\begin{matrix}CHOH\\CO\end{matrix}\right.$. Contrary to all expectations, when this oxycamphor was investigated, it was found that its physiological properties did not correspond to those of the parent camphor; that whereas the latter was a powerful stimulant for the brain, and especially for the medulla oblongata, the oxycamphor, upon the other hand, had no stimulating effect whatsoever; and that upon the respiratory centre in the medulla oblongata, it acted as a powerful sedative. Oxycamphor is a white crystalline powder, soluble in two parts of cold, but freely so in hot water. It is readily soluble in alcohol. The solution has a slight peppery, bitter taste.

The action of oxycamphor upon warm blooded animals is entirely different from that of camphor. The latter substance produces exitation of the brain, shown by excitement, delirium, and convulsions, together with stimulation of the medullary centers producing rise of blood pressure and increased frequency of respiration. With oxycamphor, we find none of these signs. There is no indication of any excitement, no disturbance of mentality in any direction whatsoever. The blood pressure is in no wise altered even by large doses. The respiration, however, is very decidedly influenced, even by small doses of oxycamphor. If one-quarter gram be injected subcutaneously, or one gram be administered by mouth, to a rabbit, the respiratory movements become more quiet and regular, more superficial and markedly slower. Intravenous injection is followed by cessation of respiration. Manasse and Heinz have shown that this effect upon respiration is due to depressant action of oxycamphor upon the respiratory center in the medulla oblongata, for in animals in whom respiration has ceased after administration of the oxycamphor, stimulation of the phrenic nerve is followed by contraction of the diaphragm upon that side. Hence oxycamphor is a drug which specifically diminishes the excitability of respiratory center. It would therefore seem to be the remedy par excellence in the treatment of asthma. The etiology of asthma in spite of long continued acquaintance with the disease, and of careful study of its symptoms and of the conditions under which they arise, is still a very obscure problem. In a rough sort of way we may divide the various forms into two grand divisions. First, the secondary or symptomatic group in which some peripheral irritation is the cause of the attack; such are those cases which arise from the lesion of the nose, of the bronchial membrane, of the stomach, or of the uterus. Secondly, we have the idiopathic variety, in which the symptoms are the same, but in which no cause for the trouble can be detected by the most careful search during life or by a most pains-taking post-mortem investigation. We must be struck by the analogy which the disease bears in this regard to epilepsy, where we likewise have a symptomatic and an idiopathic form and in which neither macroscopic nor microscopic investigation enables us to locate or define the ultimate lesion. In the case of epilepsy, we have a cramp of the voluntary muscles of the body; in asthma we have a similar cramp of the diaphragm, the bronchial muscles and of the muscles of respiration.

I do not doubt that future investigators, operating with better means of inquiry, and armed with methods of recognizing molecular changes in ganglionic cells, will be able to find the diseased organs which must undoubtedly be present in both diseases. Until such discoveries shall have been made, we must consider both of the affections as neuroses, that is to say diseases of the nervous system without gross, anatomically recognizable lesions. Every thing that we know of asthma points to a nervous origin, which we will better understand if we recall the nervous mechanism of respiration. The automatic act of respiration is kept in operation by a peculiar reflex, whereby the inflated state of the lungs, calls forth expiration, and the collapsed condition induces inspiration.



1.—Muscle Inspiration. 2.—Motor Center Inspiration. 3.—Motor Center Expiration. 4.—Muscle Expiration. 5.—Sensory Center Inspiration. 6.—Sensory Center Expiration. 7.—Lung in Inspiration. 8.—Lung in Expiration.

The accompanying diagram will make the procedure clear. In this figure we have represented the inflated and collapsed lung, the receptive centers of inspiration, the emissive centers of inspiration and of expiration, the muscles of inspiration and of expiration, and the nerve fibers uniting these several parts. When the lung is expanded a centripetal influence passes to the sensory center of inspiration in the medulla and thence to the motor center of expiration, innervating the muscles of expiration, and the lung becomes emptied. The condition of expiration, leads to excitation of centripetal fibres passing to the sensory center of expiration, the influence passes thence to the motor center of inspiration and the lung becomes inflated. The rate of expiration depends more than any thing else upon the condition of irritability of the respiratory center. If the center be in a condition of excessive irritability from the action of blood devoid of oxygen, frequent respiration is the result. If the irritability be diminished by blood surcharged with oxygen, or through the action of depressants like morphin, the rate of respiration is slowed. Now almost all of the remedies which have been found to be of service in asthma are such as have narcotic properties, like opium, stramonium, belladonna, etc., and act as depressants upon the respiratory center. Among them all there is no remedy, whose action seems to be limited to that center, and to have no influence upon the circulatory center and upon the rest of the brain, as is the case with oxycamphor. Even with healthy individuals the reduction of the excitability of the respiration centers produced by administration of oxycamphor can be very easily demonstrated. If we measure the period during which an individual can hold his breath, and then administer a dose of oxycamphor, we will find that the period has become very markedly lengthened, showing that through the effect of that drug the irritability of the respiratory center has been very decidedly diminished, so that a larger quantity of carbon di-oxide in the blood than is normally the case, is necessary to compel respiration. The expectations, that were raised by experiments made upon animals with oxycamphor, have been fully realized by clinical observation. In the larger number of cases of asthma, and dyspnea from affections of the lung or heart, oxycamphor acts even as vigorously as morphin and as rapidly. I have seen an asthmatic attack decidedly lessened within ten minutes after taking fifteen grains of the remedy, and within a short time disappear entirely. This highly gratifying result is not attended as a rule, with any unpleasant symptoms, as far as I have observed; although other investigators have occasionally noted nausea and repugnance to the drug. In my hands it has sometimes failed to have the slightest effect, in spite of vigorous dosage, but this has been quite exceptional—so that I have come to regard it as a most valuable remedy. In one case in which 15 grains were given at night to prevent a possible seizure, an attack followed within 5 minutes after taking the dose, the same result occurred the following night, although in this case, the attack had otherwise occurred only toward morning. In order to prove that the asthmatic attack was produced by the remedy, it was given a few days later in the afternoon, and again within ten minutes, a severe attack of asthma set in. This is the only case in which such an observation has been recorded.

Oxycamphor in the crystalline state decomposes very readily. It has therefore been sent out by the manufacurer dissolved in alcohol under the name of oxyphor,—containing 50 per cent of oxycamphor. This oxyphor may be given in doses of from ½ dram to 2 drams. I have been in the habit of prescribing it dissolved in simple elixir, in the proportion of one part of oxycamphor to 7 of the elixir so that each tablespoon full of the mixture contains ½ dram of the remedy. In this form it is readily taken by the patient and does not decompose. I have been informed by Dr. Graves that he has obtained markedly beneficial results in the treatment of whooping-cough of children from doses of from 5 to 30 minims of oxyphor. These doses were never followed by unpleasant symptoms, but following the administration, the attacks in four cases rapidly diminished in number, and soon ceased entirely. In cases of severe dyspnea from affections of the heart, lungs, or kidneys, a decided amelioration of the respiratory symptoms has been frequently observed. As the casual trouble is not reached by oxyphor, the improvement is only subjective, and has little or no influence upon the final results. To sum up our experience with the drug, it is safe to say, that we have in it a valuable addition to our pharmacopeia—one that we can safely use to take the place of the various narcotics in the treatment of different forms of dyspnea.

UREMIC COMA FROM OBSTRUCTION OF ONE URETER DUE TO A FLOATING KIDNEY — NEPHRORRHAPHY, RECOVERY.

By Emmett Rixford, M. D., Professor of Surgery, Cooper Medical College.

Read Before the San Francisco Medico-Chirurgical Society

The case, whose history is here given somewhat fully, serves excellently to illustrate the fact that serious compression of the ureter may be caused by floating kidney and that sudden occlusion of one ureter may give rise to serious, and if not relieved, even fatal uremia. It also presents a number of features of importance in the matter of diagnosis and treatment, among other things the value of catherterization of the ureters and the ease and thoroughness with which the ureter may be explored by means of a sound introduced into it through the bladder and an oblique incision in the flank.

Mrs. H., aged 32, English, was brought to the City and County Hospital, April 14th, 1900, in a condition of semistupor. She was also slightly delerious i. e., when left to herself, she would be somnolent but would occasionally sit up and mutter unintelligibly. However when roused and asked direct questions she would answer with apparently perfect intelligence and clearness and then in a few minutes would relapse again into a condition of drowsiness and uneasy sleep. During sleep she would have occasional twitchings of the arms and legs and would at intervals awaken and cry out with pain in the right side of the abdomen. She vomited frequently. Examination found marked spasm of the muscles of the whole abdomen more intense on the right side. Pressure here caused pain. The area of maximum tenderness was near the edge of the ribs. The pain was described as a constant ache with occasional darting, stabbing pains, extending upwards to the right shoulder. The pain and the efforts at vomiting were increased by turning the patient on the right side. The abdomen was not distended and there was no particular tenderness in the region of McBurney's point. The pupils were moderately contracted. The skin moist. Temperature 99.8°, pulse 98, small and of low tension; in the evening the same. The spasm of the abdominal muscles was so great that satisfactory palpation of the abdomen was impossible. No tumor could be made out. Digital examination through the vagina was negative. By repeatedly arousing the patient and sharply questioning her it was learned that she had several attacks similar to this, characterized by pain, vomiting and dizziness, coming on without apparent cause and considered by her to be ordinary bilious attacks. Eight days before entering the hospital, the patient while nursing a large heavy man, suffering from dementia, had occasion to lift him several times. In the afternoon, being fatigued, she drank by mistake instead of brandy about half an ounce of the patient's medicine, to which she attributed her illness. In the night she had difficulty in urinating, began to vomit, and had some pain in the region of the umbilicus. She was sleepy all the next day, and had considerable pain. Neither the pain or the vomiting were relieved by lying down; when she tried to urinate the pain increased. A physician was called, who prescribed a cathartic and bismuth for the vomiting. The symptoms were not relieved however and the physician advised taking the patient to the hospital. After waiting 5 or 6 days Dr. W. B. Coffey was called, to whom I am indebted for the following description of the condition of the patient before she entered the hospital: "The patient was almost in collapse with small rapid pulse, was bathed in cold perspiration, was vomiting almost continually and complained of severe pain in the right side; there was rigidity of the abdominal muscles, and pressure on the right side, where an indefinite tumor was made out, caused pain and increased the efforts of vomiting." Dr. Coffey turned her on her face and even hung her on the edge of the bed with head down to see if such a position would give relief. This failing he insisted on the patient being brought at once to the hospital. Patient said that she at times seemed to lose consciousness; at other times she would see strange things and hear strange noises. She stated that the bowels had not moved for two days, and then only after several enemas had been given. Accordingly a high enema of soap and water was given, it brought away a large fluid stool, black in color as if from bismuth. As is our custom in all cases where operation is likely to be required, the abdomen was shaved and scrubbed and covered with a compress wrung out in 2½ per cent carbolic acid and a nurse set to observe the patient as closely as possible. Next day, April 15, the somnolence had increased; there was more pronounced delirium; all food was vomited. Amount of urine in last 24 hours, 20 ounces; specific gravity 1.015; pupils were slightly contracted and slight twitching of muscles of arms and legs was observed; temperature subnormal, 96.8°; pulse, 98. In the evening the temperature had gone to 99.6°, and the pulse 118.

April 16. When seen at 10 a. m. patient was in complete coma. Muscles of abdomen were strongly spastic; clonic spasms of muscles of arms and legs; pronounced oder of urine from breath; skin dry; temperature, 98.4°; pulse, 116; amount of urine in 24 hours preceding, 22 ounces; specific gravity, 1.915. Patient was given a hot air sweat and a quart of 0.6 per cent salt solution under the breast. The condition, remaining unchanged in the afternoon, the ureters were catherterized, Kelly's instruments being used; patient in dorsal position with hips raised. A whalebone probe entered the right ureter only two inches, being arrested apparently by the curvature of the ureter, but the flexible gum elastic catheter entered ten inches as measured from the mouth of the Kelly's speculum; urine flowed drop by drop from the left kidney, but none came from the right. The patient was completely unconscious, and the catherterization was done without the slightest difficulty; the bladder mucous membrane was normal in appearance, save for slight congestion about the right urethral orifice. No blood was brought by either catheter.

From the history as given above of pain, diminished secretion of urine, the presence of uremic coma and the complete stoppage of the right ureter, the diagnosis of impacted calculus was made. To make it more certain, following Kelly's suggestion, a catheter was tipped with paraffine and inserted into the ureter as far as it would go in the hope of bringing away particles of grit or of having the paraffine scratched by the stone. A lense failed to show either. The finger in the vagina found no stone near the lower end of the ureter. Operation was evidently imperative, and accordingly an incision 8 inches long was made, extending from the junction of the twelfth rib and outer border of the erector spinae muscle obliquely downward and forward nearly parallel to Poupart's ligament. The peritoneum was lifted forward, and the kidney was found displaced downward about 4 inches. Lifting it in place the ureter was at once filled with urine, which began to run from the catheter which had been left in. The ureter was then carefully explored with the eye and finger from the pelvis of the kidney to an inch below the iliac vessels. No calculus or tumor was found. The kidney was very movable, enabling its pelvis to be thoroughly palpated between fingers in front and behind. The kidney itself seemed quite normal, save for its deep color, due evidently to venous congestion. The catheter in the ureter extended to within 3 inches of the pelvis of the kidney, and was readily palpated in the examination of the ureters. From the position of the kidney it seems certain that the occlusion of the ureter occurred by reason of acute flexure near the pelvis of the kidney. No tense cicatricial or other band was found, nor was the pedicle of the kidney twisted upon itself.

The capsule of the kidney was split for two inches on the lower dorsum and stripped back half an inch on each side. It was not abnormally adherent. Chromic acid catgut sutures were inserted, two through the substance of the kidney, entering about a quarter of an inch in depth. In the tying one of these cut out. Neither this cut nor the needle holes in the kidney bled noticeably. The wound was closed without drainage, the muscles being sutured with chromic acid catgut and the skin with buried catgut. The catheters were left in the ureters about four hours, during which time small but equal quantities of urine were secreted from the two kidneys.

April 17. A hot air sweat was given in the night, though before perspiration became noticeable the heat had been applied for an hour and a half. Patient slept a good deal, but was delirious when awake. Very little urine was secreted, but the specific gravity rose to 1.024. A quart of 0.6 per cent salt solution was injected beneath the breasts and bicarbinate of soda given in 30-grain doses every hour for eight hours. The temperature rose to 100° (surgical aseptic fever). Two or three enemas were given and brought fair results. The urine was mostly voided involuntarily or with the enemas. The patient had had no food for so long (8 days) on account of the vomiting, that it was considered imperative to feed by the rectum. She was at times so delirious as to be unmanageable. She complains of various abnormal sesations, numbness of the fingers and toes. Pupils still sharply contracted.

April 18. The urine began to flow freely. It was voided many times involuntarily, and bowels moved sometimes involuntarily; delirium less; pupils less contracted; temperature, 98.6°; pulse, 100. Thereafter patient steadily improved, though for some days the bowels moved involuntarily and the urine voided at the same time was lost. She complained of various curious sensations and evident hallucination—she was sure for a number of days that her mouth was drawn to one side and she was troubled because everything she saw was reversed, right being left. The delirium gradually subsided, the pupils enlarged to normal, the temperature went no higher than 100.2°, and this on the second day after the operation. The pulse gradually fell from 120 on the second day to 84 on the fourth day. The wound healed by primary union and gave no trouble.

At the date of this writing, September 3d, patient reports that she has had no evidence of floating kidney or any symptoms suggesting renal calculus, and there has been no sign of uremia.

Reviewing the case, it seems established that the occlusion of the ureter was due, not as is usually the case in obstruction from floating kidney, to twisting of the pedicle of the kidney, but to sharp flexure of the ureter, brought about by the prolapse of the kidney. With equal certainty the obstruction was not due to some small stone, which escaped detection. This is evident from the fact that the soft catheter had been introduced into the ureter some three inches above the pelvis and brought no urine; in fact no urine ran from the catheter until in the operation the kidney was exposed and lifted into place, when, immediately, the ureter filled with urine and a flow occurred through the catheter. There certainly was no obstructing stone near the pelvis of the kidney, for it would have had to be of a size large enough to have been felt in the careful palpation which was made of the pelvis of the kidney and the ureter.

1400 Van Ness Ave.

BRIGHTS DISEASE AND THE CARDIAC HYPERTROPHY OF CHRONIC PARENCHYMATOUS NEPHRITIS.

By J. J. Clarke, M. D.

Read before the San Francisco Clinical Association Oct. 9, 1900.

Dropsy, as anasarca and ascites, was well known to the ancients.* It was associated with the effects of drink and afterwards with diseases of the heart; but renal dropsy, as distinct from hepatic and cardiac was only recognized about ten years after Laennec's great discovery, although its character must often have been noted previously.

In 1827 Dr. Richard Bright published in his "Reports of Medical Cases," the fact that in many cases of dropsy there are well-marked lesions of the kidneys and that the urine is albuminous. His discovery was the connection between the clinical symptoms of dropsy and albuminuria, and the anatomical fact of renal disease. That dropsy is often attended with the presence of serum in the urine had been pointed out by Dr. Wells of St. Thomas Hospital, by Dr. Blackall of Exeter, and Dr. Osborne of Dublin; in the previous century it had been noted by Drs. Cotugo and Cruikshank. But notwithstanding that Wells and Blackall each made autopsies in which they found the kidneys "remarkably hard" they both regarded the presence of disease in these organs as accidental. Blackall's hypothesis was that serum was excreted by the kidneys because it was vitiated, possibly from having already formed part of the dropsical fluid, and having been thence reabsorbed into the blood. To Mr. Bright belongs the full credit of first showing the real and constant relation of disease of the kidneys both to dropsy and albuminuria, and his name is therefore justly associated with it throughout the world. A difficulty which has stood in the way of all subsequent writers is that the lesions of the kidneys described by Mr. Bright vary greatly. He himself and his fellow workers admitted three forms of the affection leaving it an open question whether or not they should be regarded as separate diseases.

The three anatomical types of "Morbus Brightii" recognized by Barlow, Rees and Wilks, were the large red kidney, the large white kidney, and the small red kidney. Rayer, who first followed Bright's footsteps in France, divided what he called *nephrite albumineuse* into a much greater number of varieties. In 1851, Professor Frerichs, then of Breslau, propounded the doctrine that the diverse appearances presented by the kidneys belong to the successive stages of a single morbid process. This view, however, was refuted two years later by Dr. Wilks, who showed in the "Guy's Hospital Reports"† that, under the name of Bright's disease, there are included at least two independent affections differing in their causes, in their mode of onset, their symptoms, and their course—"the large white kidney with considerable dropsy" and "the hard contracted kidney, often destitute

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*** Aretaeus, who flourished in the first century; Celsus (probably contemporary).**

† Second Series, Volume III.

of symptoms"—and added a summary of twenty-three cases of the former, and thirty-three of the latter affection. Wilks reasoned that since anasarca is particularly associated with the "large white kidney" one ought, if it were an early stage of the "small red kidney," to obtain a definite history of there having been at a former time an attack of dropsy in each case in which a small red kidney was found after death. Frerichs, however, had not brought forward a single instance in which there had been this sequence of events, nor were any furnished by Wilk's own experience. The statement that the large white kidney does not pass into the small red kidney may be put too absolutely; but in the main it is undoubtedly correct. Moreover, it is not uncommon to find, in the bodies of those who had died of various diseases, kidneys showing all the stages of the morbid process by which they gradually become shrunken; and none of those are marked by enlargement. As for the other points of distinction pointed out by Dr. Wilks, it might be briefly stated that, whereas the large white kidney often results from scarlet fever, or from exposure to cold, the small red kidney is not traceable to either of these causes, but in many cases to gout or plumbism; that whereas the former occurs in children and young adults, the latter is rare under five-and-thirty, and is not frequent before the age of fifty; that the former is often abrupt in its onset and acute in its course; while the latter always begins insiduously, and is very slow in development and lastly; that although either may be attended with changes in the heart and arteries, such changes are far less marked in the former than in the latter kind of Bright's disease, which often appear clinically under the mask of cardiac symptoms, or of apoplexy, due to rupture of an artery in the brain.

A satisfactory definition of Bright's disease is very difficult. It should not include temporary symptomatic albuminuria, such as accompanies the venous congestion of heart disease or the secondary albuminuria of cholera, or the febrile albuminuria of erysipelas, diphtheria, or typhus. It should not include any case in which transitory albuminuria occurs without there being reason to suppose an organic change in the kidneys and, lastly, it should not include cases in which the presence of albumin is only due to that of blood, pus, or of hemoglobin. Taking these reservations into account we may perhaps say that by Bright's disease is meant primary diffuse nephritis, attended with persistent albuminuria. Clinically, however, there can be recognized two well-defined varieties of Bright's disease—the acute and the chronic.

Further specific divisions it is not my purpose to treat in this paper, excepting as such departure may bear upon the cases in point, but my desire is to draw from my case books a line of histories and a series of three diseases, which have interested me during the past four years, together with a line of treatment which may enable others to develop, providing the question is considered of sufficient interest.

Acute and chronic tubal parenchymatous nephritis, acute Bright's disease is a tubular inflammation, which may be wholly recovered from, prove fatal, or lead to chronic parenchymatous nephritis. Chronic Bright's disease may be described under three separate heads, namely, chronic parenchymatous nephritis, interstitial nephritis or cirrhotic kidney, amyloid degeneration or waxy kidney. These divisions, however, we may suspend entire or in part, providing we cling to the main or so-called chronic parenchymatous nephritis, which may be a sequela of the acute form, but is oftener a chronic degenerative process from its onset. Under the latter head may be included the large fatty kidney, the large white kidney, and the small, granular, fatty kidney. Chronic parenchymatous nephritis is almost always a legitimate consequence of depraved cell-development, and it may make its appearance in any form of renal lesion in which there is a protracted interference with the normal nutrition of the tubes. In the large, fatty kidney, but few of the epithelial cells of the uriniferous tubes at first undergo change, but as the transformation becomes general, the entire contents of the affected tubules become loaded with minute oil globules. The mucous membrane of the pelvis and calices is thickened, opaque, and anemic, or it presents a varicose dilatation of its veins. The kidneys are enlarged, their capsules are non-adherent, and their surface smooth, their color is paler than normal, presenting a more or less yellow appearance, sometimes they are mottled. On section, the enlargement of the organ will be found to be due chiefly to an increase in the size of its cortical substance, which is of a pale, yellowish color. There is but little change in the medullary portion. The Malpighian tufts stand out prominently, for there is more or less fatty material in the dilated portion of the uriniferous tubes around the Malpighian tufts, which gives them a somewhat pale appearance. The vascularity of the whole kidney seems to be very much diminished; but here and there spots of hemorrhage or congestion are seen. The principal changes take place in the convoluted tubes or the cortical portion, especially in those which surround the Malpighian tufts. This form of Bright's disease may be ushered in by acute symptoms or come on insidiously; in either case, when once fully developed, the symptoms are identical. There are two symptoms which are always present, namely: albuminuria and dropsy. If its advent is marked by acute symptoms, its development is attended by the phenomena of acute Bright's; the patient rapidly reaches a condition of general anasarca; his countenance assumes a pallid appearance; but the pallor is not like the clear pallor of phthisis, nor the dingy pallor of cancer, but is peculiar to the disease. When such a patient has reached an apparently hopeless condition his urine becomes gradually increased in quantity, his appetite returns, nausea disappears, he suffers less from restlessness, the anasarca gradually diminishes, the sleep becomes refreshing; in short, there is a gradual improvement in all the symptoms. This improvement may be continued or relapses may occur, but after a few months he may reach a condition of comparative health; this class of patients never so far recover that no traces of the disease remains There will always be some edema along the line of the tibia and over the internal malleolus, and the albumen will never entirely disappear from the urine. Patients in such a condition are invariably inspired with the hope that they will reach complete recovery; but they are liable at any time to a sudden return of their dropsy. It is to be remembered that the symptoms and course of this form of Bright's disease are anything but continuous; there will be remissions, periods when these patients seem to be recovering, and suddenly the urgent symptoms of chronic anemia will develop, and the patient passes into a state of listnessness, stupor, of symptoms"—and added a summary of twenty-three cases of the former, and thirty-three of the latter affection. 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When the urine is abundant, of a pale color, low specific gravity, highly albuminous, and contains fatty, granular and hyaline casts, accompanied by edema of the lower extremities, one readily makes a diagnosis of chronic parenchymatous nephritis, especially if a careful analysis of the history of the patient corresponds to the usual course of its developments. If the urine is carefully examined it is hardly possible for one to confound the anemia and cachexia which sometimes attend the stage of atrophy of chronic parenchymatous nephritis with the cachexia of other chronic diseases. The mistakes that are made in diagnosis, or rather the failure to recognize its existence, are usually due to the fact that a careful examination of the urine has not been made. In every case of persistent dyspepsia careful examination of the urine should be made and I favor the nitro-magnesia test which is used at the Universities of Edinburgh, New York, and Berlin, since this gives a vastly more delicate reaction, if the cold process of analysis is only at hand, as in a consultation practice for instance.

One of the most constant attendants of the advanced stage of this form of Bright's disease is the development of cardiac hypertrophy, which is due to interference with the systemic capillary circulation, and it is an evidence that the renal disease has existed for a long time; it suggests the possible occurrence of cerebral hemorrhage, and therefore renders the prognosis unfavorable; visceral inflammations, especially pneumonia and bronchitis, are liable to occur, and often are the direct causes of death.

But to the treatment, for every physician is familiar with the gross pathology, differential diagnosis, prognosis diet, and the many other sides that are more or less familiar to all, and I doubt not but that every late form of treatment has also been employed with the usual varying success. Given accurate drugs and chemicals, then, we are equipped to battle for life, if need be, to the last trench, and I will show you that this is really true before concluding. Our sheet-anchor in Bright's disease is digitalis, and it should be exhibited in moderate doses, or at intervals, but it is always indicated. It is important that the accumulations in the uriniferous tubules (debris) should be removed in both the acute and chronic disease. Digitalis does this. Digitalis is a very old remedy comparatively, and in former days it was noted that its action was to slow the heart if given continuously, and also to make the heart beat intermittently, and hence it was classed as a pure cardiac sedative. Digitalis produces a peculiar tonic contraction of the heart, particularly of the walls of the ventricles. The contraction is not uniform, however, but cramplike, not all the fibres of the heart equally participating; and so the heart presents a streaked or nutmeg appearance, as it is called, owing to the contracted fibres turning pale, those not contracted remaining relatively redder. This contraction is mainly due to the prolongation of the systole at the expense of the diastole. Digitalis increases the systole at the expense of the diastole, and if given continually, even where there is a normal heart, causes death by increasing the systole without any subsequent diastole or reaction, the heart cavities growing smaller and smaller. This demonstrates the uses and dangers of digitalis, and explains, when acting as a poison, one symptom particularly, namely, the intermittency of the pulse, because the heart does not relax and skips a beat. With this condition there is persistent and dangerous nausea and vomiting. Apparently, therefore, digitalis is a typical medicine for dilation of the heart, or an embarassed circulation of Bright's disease; but unfortunately, it has another effect, namely, it contracts not only the heart, but also the muscular coats of the arteries: not the aorta—for there the coat is elastic—but the small arteries, and the smaller they are the more they feel the effects of the drug. How does it do this? On the coats of the arteries the vaso-motor nerves are distributed, and whenever there is a division of the artery there we find a little ganglion, and at the next division another little ganglion of the vaso-motor system, and so on. These ganglia, instead of being acted upon all at once, are sometimes acted upon from the periphery, as in Bright's disease, or, as when digitalis is administered, from larger ganglia downwards. So in the latter case we find that when the heart and kidneys are through with the action of digitalis, the smaller arteries are not, and so there is an obstruction not in the uriniferous tubes this time, but in the smaller blood vessels. The addition of nitro-glycerine, however, overcomes this arterial obstruction, and we lose nothing of the action of digitalis on the heart in combining these two drugs with strophanthus, as nitro-glycerine itself is a cardiac stimulant. This combination was first used by Dr. Hope of London, and has since been employed by many clinicians, including the eminent Dr. Alfred L. Loomis of New York, one of whose patients designated the formula the "golden pedistal pil." This formula has done admirable work in my hands, but not particularly so of late years, whether from pure drugs or otherwise we may all draw our own conclusions. Early in February of this year my attention was invited to a new formula said to be of advantage in the treatment of dropsical effusions, cardiac hypertrophy and Bright's disease. As I remember, it was not advocated in any way as a cure, but simply as a means of equalizing the circulation and prolonging life. Such a claim was considered modest enough, and it appealed to me for no other reason than that I had gotten to the end of my patience with the quality of my drug supply, and my anxiety to accomplish something for several desperate cases then on hand. I grasped at this, then, much as a drowning man will at a straw. This formula contains, I believe, tinct. digitalis, tinct. strophanthus, scillipicrin, scillotoxin, the latter being alkaloids simply of scilla martima, and lastly oxysaponin, which is obtained from herniaria glabra. The chemistry of oxysaponin, occurs as a grey, amorphous powder with a pungent, irritating odor, is sternutatory and has a flat taste. This is a glucoside like that obtained from quillaja bark. Oxysaponin so-called, when administered alone causes very liquid passages, but the combination as a whole gives only one result with which I am already familiar. I have been unable to gain any information as to the ultimate results on diseased kidneys of this formula, because no autopsy is as yet forthcoming, but I believe that we have a combination with which many of us are already familiar, the only difference being that in this preparation we have absolutely pure drugs, therefore if hydragogin is nothing else than this, it holds a place in medicine of the most useful and satisfactory nature. Having, as I said, several cases on hand that had resisted every effort upon my part, I used this formula, and found strangely enough that my patients improved at once, and for some reason they are still doing well, although I had not expected three of those under consideration to live longer than last June at the very outside limit. Now I am not given to promiscuous remedies as a rule, but depend on both German and English chemical sources for accurate chemistry, and of these I feel positive, being perfectly familiar with the Prussian government's standards as regards accuracy in this line of work. That I have a pure mixture of digitalis, strophanthus, and squills I am perfectly positive, and I am also sure that my patients have improved steadily. Since the beginning of February I have had nine other patients on this formula, and up to the present time all are doing very well, several of them going about their daily occupations, and enjoying comparative freedom from any urgent condition for the time being; but of course I can chronicle no cures, nor am I foolish enough to expect this, but if I can keep such patients in a comfortable condition for the remainder of their natural lives, I shall be satisfied. I would like to know more about the experiences of those who are using this formula, and therefore have written this paper and read it before you with the object of gaining light upon not only the experience with hydragogin, but upon its therapeutic activity as a useful medicinal product.

21 Powell Street.

SARCOMA OF THE KIDNEY IN CHILDREN.

By **Bertram Stone**, M. D. Crescent City, Cal.

This condition, while a comparatively rare one, is less so than is usually supposed, and as knowledge of it has increased so have the number of reports of cases. This may be due to a more correct recognition and diagnosis of malignant tumors of the kidney in children and also in part to a real increase in the number of cases, which may have taken place in conjunction with the general increase of cancer during the last thirty or forty years. Practically nothing was known of this condition prior to 1830, although a few articles made some reference to cancer of the kidney as early as 1817, yet in a very incomplete and ambiguous manner. Since that time more study and investigation has been given the subject, and our knowledge of this serious lesion materially increased. At first these cases were thought to be carcinomas, but more complete investigation has shown that about 95 per cent of malignant tumors of the kidney in children are sarcomas, either round, spindle celled or myo-sarcomatous.

The cause still remains doubtful, the most probable being that the tumor is developed from misplaced portions of embryonic tissue, and, therefore, a disturbance of development. The condition may be congenital but seldom gives any evidence of being hereditary. The development is often ascribed to an injury, as a fall, a kick or some similar traumatism; this seems a doubtful assumption as the kidney is very well protected, and it would be very difficult to cause an injury of so serious a nature without doing great harm to some other organ not so well protected; however in my case it seemed to have the effect of causing a rapid increase in the growth. This form, nearly always primary, is seldom secondary to sarcoma in any other organ of the body, although growths secondary to kidney lesion are fairly common involving almost every organ, lungs, liver, brain, etc. The sarcoma may be either round or spindle celled or myosarcomatous, and may grow from the cortex or the pelvis of the kidney, and occasionally from the adrenals. The growth may involve the whole kidney, leaving no trace of renal structure or it may form an immense tumor to one side of the kidney involving but a part of its substance. It varies in size, to a weight of 35 or 40 pounds; 5 to 15 being the usual weight. The surface of the tumor may be lobulated, irregular or smooth, and although the tumor is usually solid it may seem quite soft and even give the sensation of fluctuation on palpation. It is rarely cystic though one is occasionally found which contains a number of cysts from the size of a walnut to that of a large orange. Hemorrhage into the substance is quite common, and probably due to the extremely thin walls of the vessels traversing the growth. The tumor is often adherent to the abdominal organs, the result of a localized peritonitis. General peritonitis is however quite rare, ascites is more common than general peritonitis, but is still rather uncommon. Edema of the legs often occurs when the growth is large enough to obstruct return venous circulation. It may also cause dyspnea by encroaching on the movement of the diaphragm. Digestive disturbances occasionally occur, but are of no assistance in diagnosis.

The principal symptoms are pain, renal hemorrhage, and tumor. The pain is sometimes absent and even when present is usually of a non-distinctive character, being dull and confined to the lumbar region, very seldom being severe enough to cause the patient to make any complaint. Renal hemorrhage is supposed to be present at some period of its course in at least one-half of the cases. A renal hemorrhage without external cause running its course without pain should be looked upon with suspicion.

TUMOR.—This is practically the only symptom of much value, and is usually easily found, if looked for or when it is grown to such a size as to cause a noticeable enlargement of the side. It usually starts in the loin, but grows toward the median line, and often with great rapidity; at times growing from the size of the fist to a size nearly filling the abdomen in a month or two; this being an important difference between malignant and benign tumors which usually grow very slowly. The tumor is not movable on respiration, and in the majority of cases the colon lies over its surface, which if filled with gas can be outlined by percussion.

The case seen by me was a girl, three and a half years old; parents both healthy; child never sick to the parents knowledge until about 2 months previous to my seeing her, when she fell a distance of about four feet, striking over the region of left kidney on the corner of a box. For two days there was almost anuria, followed for about a week bv plentiful urine, looking very much like milk, but rather heavier; she also suffered a good deal of pain during that time in the region of the kidney, and was rather feverish. In the course of two weeks she seemed to have recovered her normal condition, but in the course of a few weeks her parents noticed a swelling of the left side of her abdomen beginning in the loin, which gradually increased in size, extending toward median line. The child, as then brought to me, with a tumor in left hypochondrium, the size of a large adults head, could be easily discovered. Child seemed well nourished, appetite good, bowels regular, sleep normal, no pain, urine seemingly normal, although I must confess that I did not examine it as closely as I should, as I felt the diagnosis was clear enough without that. Operation was advised and the parents decided to consider it, but it was nearly a month before they concluded to have it done. When the child was next seen, the tumor was found to have increased remarkably, filling almost the entire abdominal cavity, giving a feeling of fluctuation on palpation; feet and legs were edematous; veins on abdomen enlarged; some dysnea; bowels constipated, but very little pain. The parents were informed of the doubtful results to be obtained now by operation, but as they wished it done an operation was attempted. Upon exposure of the tumor through an abdominal incision it was found to be smooth, of reddish color, quite soft and adherent to a number of organs, which caused some little trouble in their separation. It was finally removed, although considerable venous hemorrhage occurred. The abdomen was closed, but the child only lived a short time. The tumor weighed 21 pounds, the substance inside the capsule consisting of a soft, whitish, gelatinous material; no cysts being found. The growth seemed to have taken place from the cortex, as the pelvis and a good amount of kidney structure still remained and was fairly normal in microscopic appearance. Post-mortem the other kidney was found somewhat hypertrophied, otherwise normal. No secondary deposits were found. The lesson to be learned, if any, from my case is that no time should be wasted before operating after the diagnosis is made.

HOSPITAL NOTES.

Heroin as an Analgesic.

Brown and Tompkins (Therapeutic Gazette, August 15, 1900) reports 50 cases, in which they employed heroin as an analgesic, or a hypnotic. In 34 cases, it was used for its analgesic effect, and 16 for its hypnotic effect. In all but 7 cases, sleep was induced, and pain was relieved. The action of the drug took place in 15 minutes from the time of administration in 25 cases; in 20 minutes in 18 cases; in the other 7 cases no effect was produced. The dose in 34 cases was 1-12 grain of the hydrochlorate; in 16 cases 1/6 grain was given. In 30 cases, the duration of the action of the drug was 4 hours, in 13 cases from 6 to 8 hours, and in 7 cases no appreciable effect was noted. Thirty-one administrations of the drug were given by hypodermic injection, the remaining 19 by the mouth. Vomiting was absent in all but 4 cases, and, as the administrations were made before the patients had fully recovered from the effects of ether, it would be difficult to say which was the cause of the vomiting. Contraction of the pupils and subsequent constipation were absent in all cases. We did not find any idiosyncrasy for the drug, such as has been reported by other observers. The authors conclude that heroin is a safe analgesic, one which can be repeated if necessary without producing habit, or doing harm in any way.—Phil. Med. Jour.

Creosotal.

Two and a half grams four times daily in emulsion of hot milk are said by Cassoute to be tolerated by adults in acute broncho-pulmonary affections, while children up to one year of age can be given from 0.25 cgm. to 1 gm. daily in four doses; children from four to six years of age can take 3 gm. to 4 gm. daily. The dose given in Coblentz's "Newer Remedies" is *m* iii.–v.

Cacodylate of Iron.

Gilbert and Lereboullet (Journal des Praticiens, September 1, 1900) conclude that cacodylate of iron is very soluble; that it may be readily administered either hypodermically or by the mouth; that its toxicity is very slight, and that it may be employed with advantage in all cases in which it is desirable to increase not only the number of red blood-cells, but also the amount of hemoglobin. It is especially indicated in chlorosis, and in the chloroanemia of tuberculosis. The drug is not irritating to the kidney, and so it may be employed in the anemia of nephritis. In 5 cases of nephritis in which cacodylate of iron was employed, there was, in addition to the general improvement, a marked reduction in the quantity of albumin contained in the urine. The dose to be employed hypodermically is ½ to ¾ of a grain daily, by the mouth, 1 to 2 grains or more a day.

Occidental Medical Times

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THE PROPOSED MEDICAL LAW.

In 1898 the Medical Society of the State of California appointed a committee to draught and to have passed by the State Legislature a law regulating the practice of medicine. This committee was given full power to act without further reference to the society. The law was framed and presented in the Legislature by Dr. Rowell of Fresno at the meeting of that body in January, 1899, but was withdrawn immediately on account of the lateness of the session. It is proposed to introduce it at the coming meeting in January, 1901.

The requirements of the law are very simple and very fair to all schools of medicine. A diploma from a recognized school, with letters of recommendation from two reputable persons, constitutes the first requirement. The second demands an examination before a Board of Medical Examiners from the Regular, the Homeopathic and Eclectic Schools, composed of nine members distributed as follows: five from the Regular, two each from the Homeopathic and Eclectic bodies, and selected by the State societies of these bodies. A separate examination is to be held by the latter schools in Practice of Medicine and therapeutics. Six members of this board are to constitute a quorum, hence no one school can control the board. The examination is to be practical and not technical in character. This bill, if it becomes a law, will not affect any one holding a certificate under the present law.

The Committee, having charge of this matter, have drawn upon the laws of all the states, requiring an examination to practice medicine within their territory, and after most careful consideration and consultation have framed a bill that has met the unanimous approbation of a committee from all the schools of medicine now recognized by our State laws. They have not confined their efforts to the members of the committee alone, but have sought advice from representative men all over the State. As the law now stands this State is scarcely more than a place of refuge either for those, who have proven themselves unfit to practice in those states, where a Board of Examiners exist, or for the refuse of second and third rate colleges of the country. If one will examine the list of licenses granted by the present Board of Examiners, he will find many names of persons registered, who do not live in the State, but who intend at some time in case of failure to pass an examination or for other reasons to locate in our State. If he will go further and learn what percentage of graduates are refused admission to practice medicine in those states enforcing such a law, he will find that from 13 to 33 per cent are denied the privilege by at least 30 states of these United States. What becomes of these people? Many immediately set out for California or one of the few unprotected states in the West. The licenses granted each month average from 30 to 50, and the above is the reason for this undesirable and unjust contribution to our State's population and to the lowering of the standard of our profession.

The duty, then of every physician Regular, Homeopathic or Eclectic, is to urge the representative or senator from his district to vote for the passage of this measure. It will not be sufficient for each one to expect his neighbor to attend to this, but he must *now* see his representative in person and explain the necessity, the benefits to the people and the medical profession of the proposed law. He should insist on the value to the physician and especially to the people, who are daily exposed to the ignorance and incompetency of the graduate, who, though possessing a diploma, is in many instances a serious menace to the public welfare. The circular letter of Dr. F. B. Carpenter, Chairman of this Committee, published under the head of 'Correspondence,' will explain the proposed law more in detail.

THE SAN FRANCISCO COUNTY SOCIETY.

The past year has been noteworthy in the annals of the San Francisco County Society for the excellence of the management and the value of the papers and proceedings. The meetings have been uniformly well attended and remarkably free from friction and dissension. The increase in membership has been very large. From a literary and scientific point of view the papers have in may instances surpassed those of former years. The idea of the presentation of one subject, as a symposium, on each evening has met with much favor, brought forth direct and well considered discussions and has shown the value of a little stimulus and energy in the management of the society's affairs. The exhibition of specimens and patients have been of great interest and encouraged the clinical features of the order of business, a valuable feature. The reports of all the committees were satisfactory and the members will no doubt voice the sentiment of the Executive Committee in its favorable comment of the good work for the year 1900. A feeling of genuine interest, of good will and unity of purpose has prevailed on all occasions which has brought about a spirit of hopefulness that promises well for our local organization. The retireing president and his efficient co-workers deserve the highest praise for their dignified and efficient conduct of affairs, and can well feel confident that the newly elected officers will neglect no opportunity to equal if not to surpass the record of their predecessors. The following have been chosen to preside for the year 1901: President, Dr. George H. Evans; First Vice-President, Dr. E. G. Frisbie; Second Vice-President, Dr. F. B. Carpenter; Recording Secretary, Dr. Wm. Barbat; Asst. Recording Secretary, Dr. H. E. Alderson; Corresponding Secretary, Dr. S. M. Mouser; Treasurer, Dr. P. K. Brown; Librarian and Curator, Dr. Harold Brunn.

DRUG SUBSTITUTION.

For several years the medical journals have discussed at length in one or other of its manifold forms the relation that exists or should exist between the physician and the druggist. To consider any one of the phases of this question more than briefly is impossible within our limited space. One part of this subject however deserves the immediate and earnest attention of the whole profession. Drug substitution is common to-day in every large city, and particularly so in San Francisco. When a prescription is handed a patient the physician expects that the ingredients ordered will be supplied, but daily experience will convince anyone that unless one of the cheapest and commonest drugs is prescribed that no one can rely on its being properly compounded. So common has this practice become that a large number of our physicians either fill their own prescriptions or specify that they shall be taken to certain stores, which renders the situation embarassing, since one is immediately charged with either receiving a percentage or else overcharging for the drugs. The causes that have led to this practice are many and reflect frequently on the physician and druggist as well. We do not care to apologize for either, or to enumerate the conditions that have brought about this unsatisfactory state in the filling of our prescriptions. It is certainly embarassing to allow the prescription to be prepared where "something just as good" will be supplied, or the patient will be told plainly that they can furnish something better, and in some cases have your patient told that a change of physician would be advisable. It is imperative that something should be done to remedy this evil, but no satisfactory solution has as yet been offered. Neither is it possible for every physician to carry a full line of drugs, and to dispense them in his own office, nor is it advisable always to insist that the prescription shall be compounded at a certain store, yet, unless this is done, the results in many instances are most unsatisfactory. But two remedies seem to be in any way practicable: one, to insist that the prescription shall be filled by a druggist, whose integrity is beyond reproach; the other, that the National Government will be induced to place strict supervision over drugs and medicines and the proper compounding of the prescription. Physicians are too lax as a rule under existing conditions, and druggists are too ready and willing to neglect a duty of greatest import in the welfare of our people.

NOTES.

THE PLAGUE—RETALIATION.

The following cancellation of a subscription to the Journal of the American Medical Association shows to what length some of our physicians have gone in their persistent and foolish denial of the existence of the plague.

> SAN FRANCISCO, CAL.
>
> *Journal of the American Medical Association*—DEAR SIR:—Kindly cancel my subscription at expiration of my present subscription, as I desire to wait until the Journal leaves out all bogus reports of "plague" existing or having ever existed in San Francisco as reported by political doctors. And greatly oblige,
>
> ....

Comment is unnecessary. This person in all probability has not seen a single case nor is he at all conversant with the anti or post mortem findings, yet he places himself in an ignominous way above experts of recognized ability, the latest of whom is Dr. Wm. Osler.

DR. REGENSBURGER'S RESIGNATION.

Dr. A. T. Regensburger has resigned the Professorship of Dermatology in the College of Physicians and Surgeons of San Francisco. This, following so closely upon the resignations of Drs. Potter and Laine, is a severe loss to the College. Dr. Regensburger has very recently returned from a trip to Europe, where he went for rest, study and as the representative of the New York Medico-Legal Society to the International Dermatological Congress at Paris. His visit abroad has improved his health greatly and he is most enthusiastic in praise of the courtesies extended to him wherever he went in France, Germany, Holland, Italy or Ireland, etc.

SOCIETY PROCEEDINGS.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, Tuesday, Oct. 9, 1900.

SOME ACCIDENTS FROM USE OF OBSTETRIC FORCEPS.

Dr. Henry Gibbons, Jr., read a paper, "Some Accidents from the Use of Obstetric Forceps." [To be published.]

Dr. McCone: I consider Eichelberg's lateral incisions the best method of performing episiotomy. Dr. Gibbons has pointed out the necessity of waiting for moulding of the child's head. This should not be forgotten. In rachitic pelvis the moulding of the child's head often permits natural delivery, and certainly lessens the danger of injuring the parturient canal.

Dr. Davis: Dr. Gibbons has given an interesting record of his obstetrical work. With regard to high forceps delivery, the Doctor's observation and experience thereon are quite in accord with my own. It has been my fortune, for I have not regarded it as having been due to any special skill, to have had but few deaths of the child from forceps delivery and no deaths of a mother. The importance of having a dilated or dilatable os has been very properly emphasized in the paper. I have found in cases of a rigid os that the application of 10% solution of cocaine has in most cases acted quite promptly. It is not the use but the abuse of forceps which the experienced obstetrician should condemn. While the obstetrical forceps is a two-edged sword, yet, in the hands of an experienced accoucheur is a life saving device, and certainly curtails the suffering of a prolonged and agonizing labor. If the woman is discouraged, nervous, or exhausted, greater is the reason for using them. When the head is left in a position along the floor of the pelvis for some time the danger of permanently impairing the tone of the tissues is much greater than can possibly be incurred by proper application of forceps. I am impressed that antiseptic precautions are not as carefully observed in the application of the forceps as they should be. I think it cannot be questioned that there is entirely too much carelessness in non-instrumental practice also. It should be born in mind that delivery with forceps is a surgical procedure and should be conducted with the same degree of care as almost any other surgical operation. Asepsis should be the sheet anchor in all cases. Antisepsis only when required. When the true presentation is recognized, the indications favorable and the operation done under proper precautions, I am a sincere believer in the use of the forceps.

Dr. Kreutzmann: I have listened with great interest to the instructive paper by Dr. Gibbons and can realize the great amount of work and worry he has gone through to be able to put that on record; I am speaking from my own personal experience. I want to emphasize the fact, that Dr. Gibbons has put before us, that if the required conditions such as proper size of the baby, proper size of the pelvis, rotation of the head, rupture of the water bag, dilation of the cervix, if these five conditions are not present, the application of the forceps is easily accompanied with a great deal of harm and should not be done unless we have very urgent need of use. In case of urgent indication to save life, we certainly will not wait for the presence of those conditions. But I believe it is our duty to adhere to this teaching; I have tried to do it. I know it is sometimes very hard and occasionally disappointment will be our lot. In one case I waited three days; there was no reason to act; slight contraction, rhachitic pelvis, mother and fetus well, head entering the pelvis; went home for a little rest; then suddenly the head passed through the entrance and the baby was delivered before I returned; but still we have to bear these disappointments. On the other hand I want also to say that in my experience I have learned to apply the forceps in cases even if there is no strict indication; my teacher called it "forceps par complaisance." It is not life saving but it is saving a great deal of trouble and work and anxiety. Dr. Gibbons has called your attention to the fact that in this big country babies are big also; I can endorse that. I have seen here more big babies than ever in my life before. Now, I frequently observe with these big babies a typical kind of a case; we expect at the end of pregnancy that the head has entered into the pelvic cavity in primae parae; through this a great deal of work is saved to the mother in actual labor. Now these big babies do not enter the pelvis even if the latter is perfectly normal, and during the confinement the woman has to do the extra work of getting the big head into the pelvis; the result is that when it comes to the end, there is very little progress of the labor. Certainly there is no danger either for the mother or the child; skillful application of the forceps made to the head at or near the exit of the pelvis, will quickly and safely deliver the head, whereas otherwise the labor may go on for hours and hours.

Dr. J. H. Barbat: While obstetrics is out of my line, I would like to say a word about a forceps which I have used and which I see is being highly praised by obstetricians in Europe; it is the Breuss forceps. It consists of an Elliot forcep, which is cut off at the heel of the blade, and has hinged at that point a blade similar to the Elliot but with a narrow prolongation which passes backward following the curve of the shank until it almost reaches the handle when it turns up at right angles. At the end of the prolongation is an eye, which accommodates a small supporting rod after the forceps have been applied. The hinge allows the blade to move within a radius of 60 degrees so that when the forceps are applied the handles may be kept from bearing too heavily on the perineum, and it also makes the forceps an axis traction one. This is accomplished by steadying the head by means of the prolongations of the blades, and then making traction in the proper direction. It requires a little more skill to apply these forceps, but when they are on the delivery is accomplished with much greater ease than with any other forceps that I have ever seen, and the perineum is not so likely to be torn.

Dr. Gibbons: I have little more to say upon the subject of the forceps. Of course there are many points which come up in the tabulation of my cases, which are of much interest to me, but which do not appertain to the subject in hand. Large children will influence the frequency of forceps use, and my attention has been specially directed to this feature. Ten years ago I carefully weighed and measured the babies of fifty consecutive confinements. I found all my averages high; the weight was 7⅜ pounds; the biparietal diameter 3.71 inches; the occipito frontal diameter 4.52 inches and the occipito mental diameter 5.16 inches. These are above the measurements given by many authorities. In view of my own experiences I have been surprised that Madam Lachapelle in 4,000 confinements, had but one child weighing 12 pounds. Cazeaux in 3,000 cases but one weighing 10 pounds, and Winkel in Dresden but one child weighing 10½ pounds in 3,000. In a very moderate experience I have had many 10-pound babies, and several that weighed 11, 12, 13 and 14 pounds. In my last 100 confinements 43 weighed 8 pounds or over.

LARYNGEAL TUBERCULOSIS.

Dr. R. D. Cohn read a paper, "The Treatment of Laryngeal Tuberculosis."

BASSINI OPERATION.

Dr. Campbell Ford read a paper, "The New Bassini Operation; Personal Observations."

EXHIBITION OF SPECIMENS.

Dr. Kreutzmann exhibited two specimens that were removed by celiotomy a few days ago, one being a fibro-myomatous uterus with adnexa, the other a multilocular ovarian cystoma, with the following remarks: "The specimens I have here were removed by coeliotomy last Wednesday, and I wish to demonstrate them for two reasons; first on account of the diagnosis; second on account of the method of treating the pedicle. One specimen is a uterus and adnexa with a fibroid enclosed in the cavity of the uterus. The woman had ceased to menstruate for six months, and then for several periods had flowed very profusely. The attending physician thought it might possibly be pregnancy on account of the configuration of the uterus, and on account of the sensation it gave through palpation; the mass reaching from symphysis to midway to umbilicus felt doughy, almost fluctuating. Even when the uterus had been removed, before it was cut open, it gave the impression upon direct palpation of an indistinct fluctuation. The other tumor is a multilocular cyst of the ovary; it almost gave the impression of a solid tumor. This is easily understood if we see the many small cysts that were packed one into another, containing thick, gelatinous liquid. The appearance now is changed since large cysts have been made during operation by breaking into a number of small cysts in order to avoid the liquid and diminish the tumor. These two cases, operated upon the same morning, illustrate beautifully the difficulty attending the diagnosis of abdominal tumors. It being frequently quite difficult to recognize correctly the consistency of a tumor present, many other conditions and points have to be looked for and taken into consideration. In both patients correct diagnosis was made before operation; in the case of the fibroid the cervix had been opened and palpation showed a fibroid inside of the uterus. In the case of the ovarian tumor the uterus as well as the other ovary were distinctly felt. The pedicle in both these instances was treated in the way which I have adopted for all my extirpating operations on the female genitals; that is, individual ligation of the vessels. The uterus was extirpated in the following way; the adnexa were clamped off and cut off, the artery picked up in the clamp, ligated, and the slit in the peritoneum immediately sewed over with the finest catgut. Then without any further preliminary clamping, the uterus was excised; the bladder was first dissected off bluntly after an incision with scissors had been made transversely. The vagina was entered through the cul de sac and with scissors the parametrium was cut through, keeping close to the uterus. Bleeding vessels were caught, and ligated; the parametria were drained into the vagina with a strip of iodoform gauze; the peritoneum was closed entirely over the wound, thus giving to the pelvis the appearance of a male pelvis. In a similar way the pedicle of the ovarian tumor was treated; it was clamped with forceps before the tumor was severed. This was necessary to be done in order to have the tumor out of the way before attending to the pedicle. Then the blood vessels in the stump were singly picked up, ligated with fine catgut, the clamp released and the raw surface covered with peritoneum. It takes a trifle longer to do the operation in this way but the advantages are manifold. It does away with ligature en masse. To make ligatures en masse it is necessary to use strong material and most operators use heavy silk; their results give always more or less puckering of the broad ligament; besides there always exists the possibility of adhesions forming between the cut surface of the pedicle and some intestine, since the cut surface is not sealed up; when ligating the vessels singly no sloughing will take place, no forming of sinuses, no coming away of ligatures. This treatment is in accordance with general surgical principles; when our surgeons per-form operations in other parts of the body they do not previously clamp, nor ligate en masse, but they simply cut, pick up the vessel and ligate it. From my own personal observation I am absolutely convinced that this treatment is far superior to the old unsurgical method of ligature en masse. I believe that this treatment of the pedicle is essential in avoiding pain after operation. At least I see that not one of my patients has pain in the abdomen; if the pedicle has been treated in this way; if they have been prepared carefully before operation; if absolutely no antiseptic has been used after incision; if by the Trendelenburg posture the intestines have been kept back and if the abdomen has been closed with sutures in tiers."

CALIFORNIA ACADEMY OF MEDICINE.

October, 1900.

Dr. D. W. Montgomery, the President, in the chair.

HEMORRHAGIC MENINGO-MYELITIS IN DOGS.

Dr. Philip King Brown reported four cases of acute hemorrhagic meningo-myelitis in cocker spaniels, with autopsy reports and a consideration of the relation of these cases to myelitis in general. The dogs were all seen during life, through the favor of Dr. K. O. Steers, of the veterinary department of the University of California. All were killed with dilute cyanide of potash, and autopsied immediately. The onset of the trouble was sudden in all but the fourth case, and the actual paralysis was acute there also. As nearly as could be ascertained, all had fever, but two had marked fever, ascertained per rectum before they were destroyed—in the last case due probably to a complicating pneumonia present. No etiologic features were common to any two cases. In all, the trouble began in the lumbar cord and extended upward, and in two the cervical cord was extensively involved, particularly in regard to hemorrhage. In all cases the softening was far more extensive than indicated by the hemorrhage. No bacteria were found nor were there any lesions of other organs, except the pneumonia in one case. The lesions found anatomically were the same in all four dogs, differing only in duration and extent, and consisted largely of hemorrhages into the gray and white substance of the cord and pia mater, and the loose connective tissue outside the dura mater. There were no changes in the cerebrum, cerebellum, pons, or medulla. There was no evidence of injury to any of the dogs either in the vertebral canal, or externally. He also presented some pathological specimens from dogs. The first one was a case of tuberculosis in the heart wall and pericardiuma of a sky terrier, six years old and very stout. For some weeks there had been dyspnea on exertion. In the family was a child with pulmonary tuberculosis. Autopsy showed enlargement of bronchial and mediastinal glands, and tubercles studding the pericardium. The heart itself was much enlarged, and extremely irregular in outline owing to the nodular elevations scattered over the auricular and ventricular walls. Microscopical examination showed structure of tuberculosis with large areas of caseation in the center of all the large nodules. He next presented three skulls of dogs showing a condition which he named osteoporosis. The symptoms in all three cases were those of chorea of exaggerated type. No etiological factor was to be obtained. The great thickness of the skull was not noticed during life. The dogs were all of different breed, a cocker, fox terrier and pointer. All were destroyed after various kinds of treatment were tried. The thickness of the skull was greatest in the fox terrier,—the section measuring from ⅜ to ½ inch in parts ordinarily less than ⅛ of an inch thick. The thickened bone was so soft that the thumb nail could be pushed well into it. The thickening was chiefly in the medullary part, the plates, however, also taking a small part in the process.

Dr. Wm. Ophuls in referring to these last specimens presented by Dr. Brown, said that he had not been able to find any signs of inflammatory processes. He thought that they belonged to those cases of osteoporosis found in some animals, but never in human beings.

Dr. D. W. Montgomery said that he had assisted at an autopsy where a similar condition had been found in a human being. The bones of the head were much enlarged, as also were both clavicles and one of the scapulae. When the outer table of the skull was cut through, it came off, leaving a red, porous, spongy looking mass, which looked like a granular mass. The sawing was continued and the inner plate taken off. The bones microscopically had a porous condition. He had never seen anything like it before, nor had he seen anything in the literature.

PROLAPSUS UTERUS—CYSTOCELE AND RECTOCELE.

Dr. Kreutzmann presented a patient on whom he had two months ago operated for complete prolapse and perfect inversion of the vagina, with large cystocele and rectocele. Special stress was laid upon the cure of cystocele, which the doctor considers an essential point in curing prolapse. The operation was fully described; it consisted materially in the detaching of the bladder from the vagina and from the uterus, with the idea of dislocating the bladder from its pathological abnormal position and bringing it back to its normal habitat. Care is taken not to destroy nor to remove the layer of fascia and muscle under the vaginal mucous membrane. In women past or near the menopause vaginal fixation is done. The redundant tissue of the vaginal flaps is dissected and the incision closed, the lower part of the vaginal flap being sewed directly on the uterus. If any operation has to be done on the uterus, it is done; curettement, excision of the cervix, removal of the uterus, removal of a fibroid; then posterior colporrhaphy and perineorrhaphy is made. The doctor criticised the usual operation performed for rectocele and cystocele as illogical, comparing those celes with ventral hernia; after incision in the latter instance, careful exposure of the tissue in layers is made, with careful union. The same must be done in the vaginal operations; muscle and fascia must be laid open and directly united; a simple excision of a piece of the vaginal mucous membrane and union will not do. It is immaterial what the shape of the incision is. The doctor bluntly separates after making a longitudinal incision for cystocele, and a crescent shaped one for rectocele.

Dr. J. F. McCone said that he had examined the patient and had found physiological restoration of the perineal body and the anterior vaginal wall. He had been much dissatisfied with the operations described for cystocele, and agreed with Dr. Kreutzmann that the operation ordinarly done, that of simply denuding the mucous membrane and bringing the edges together, was insufficient. The same held good in the usual operations for rectocele.

Dr. Dudley Tait said he would like to ask Dr. Kreutzmann what advantage he finds, where it is necessary to fix the uterus, in vaginal fixation, over abdominal. It would seem to him very logical to begin the operation above, fix the uterus, and then do what is necessary in the vagina. He thought recurrences, after these operations, may come one or two years after.

Dr. Kreutzmann, in closing the discussion, said in regard to the suggestion made by Dr. Tait, of the advantage of abdominal fixation over vaginal, that he had no faith in the former operation, unless the operator allows no space to remain between the uterus and the abdominal wall. Numerous instances are on record of hernia existing between the folds of these so-called false ligaments. He had been thoroughly satisfied with vaginal fixation in these cases.

MEDICO-CHIRURGICAL SOCIETY.

September, 1900.

OBSTRUCTION OF URETER, COMA—NEPHORRHAPHY.

Dr. E. Rixford reported a case of "Uremic Coma from Obstruction of One Ureter, Due to a Floating Kidney, Nephorrhaphy Recovery." [See page 379]

APPENDICITIS.

Dr. Rixford: I have also to show this rather unusual appendix removed from a boy 12 years old. The history was briefly as follows: He had a little "stomach ache" in the afternoon, which however did not amount to enough to interfere with his playing or to keep him awake that night. The next day he had a slight return of the "stomach ache" and was seen by Dr. Lyman Wilbur, who, making a diagnosis of appendicitis, had him promptly transferred to Lane Hospital. I saw him soon after his arrival and at that time the pulse was full and strong and less than 100. The muscles over the abdomen were somewhat tense, and there was slight localized tenderness over the appendix, but there were no urgent symptoms. As is our custom in such cases the abdomen was prepared for operation, as a precautionary measure, but it seemed wise to wait for the subsidence of the attack before operating. He slept nearly all night. Next morning a slight increase in the tenderness was apparent. In the afternoon the tenderness was a little greater still, but there was no vomiting nor had there been vomiting since the beginning of the attack. Because of the increase in the tenderness we determined to wait no longer. The operation was performed 40 hours from the time of the first pain. The appendix, turgid and erect, covered by an omental cap presented in the wound. There were no adhesions beyond those, which held the omental cap to the outer end of the appendix. The omentum was tied off, the appendix then removed in the usual way. In the manipulation the omental cap, which was thin and distended, burst giving vent to a quantity of thin black fluid and some gas. The peritoneum being protected by thick pads of gauze was not contaminated. On laying open the omental cap we found the tip of the appendix necrotic, a large perforation in one side of it, a concretion filling the opening, the whole floating in this thin black fluid. Having observed this thin black fluid in a number of fatal cases, we have come to regard it of serious significance. There was beginning peritonitis, as shown by the presence of a considerable amount of redish yellow serum in the general peritoneal cavity, containing a floculent precipilate and the presence of considerable amounts of white coagulum on the coils of intestines near the appendix. The wound was of course drained and healed nicely in good time. The patient made an uninterrupted recovery. The interesting point in the case was the dangerous condition present. There was nothing but a thin sac of omentum, and this distended, separating a large amount of highly infectious material from the general cavity. The appendix being widely perforated and yet the clinical symptoms were so mild as to give no index of the condition. Culture taken from the black fluid showed pure culture of bacillus lactis aerogenes.

Dr. G. B. Somers: There is some question as to the actual effect of obstruction of one ureter; as to whether or not it produces uremia; or as to what effects it really does produce. Dr. Rixford's report reminds me of a case, which I saw in consultation with him about two years ago. It was a woman with carcinoma of the uterus, which had caused a complete obstruction of the ureter. The ureteral catheter could not be passed. Abdominal section, performed for the removal of the uterus, showed the ureter was distended to an inch in diameter, hydroureter. Yet the woman showed no uremic symptoms, and, though she died after about a month, yet it was without any sign of uremia. Again, not long ago in Berlin, Landau during a laparotomy cut off the right ureter. He later found this out because the urine trickled down into the vaginal wound. He ligated the ureter. He did not remove the kidney, nor did he say anything about removing it, he simply tied it off. I saw the patient about two weeks later and she was apparently not suffering at all. There were certainly no symptoms of uremia. Professor Landau thinks there are no ill effects from ligating one ureter. Of course, we know that experimentally the ureter may be ligated without causing death. As to what is the actual cause of the coma in such cases as this I do not know, it is a question for the immediate future.

Dr. Rigdon: My attention was attracted by the statement, made by Dr. Rixford in the history of his case, in which he calls attention to the low amount of urea, as shown by the specific gravity of the urine and by the small amount. This recalls some experimental work done by me some years ago, in estimating the quantity of urea. I did this for a considerable period of time, for symptoms referable to the kidney, and was somewhat surprised at the results obtained. One case, which I particularly recall, a woman, who, for a considerable period of time, had not more than five or six grammes of urea in the urine of 24 hours; and yet, during the period of several months over which I observed her, she did not have uremic symptoms. I must say, however, that I attended her in a confinement about two years before, and she did have at that time, uremia. She finally died of tuberculosis. A number of other surprising things was shown by the experiments referred to, but one thing was brought out very clearly, and that was, that a low amount of urea does not necessarily lead to uremia, much less to uremic coma. The symptoms of floating kidney, are to be arranged in three categories: 1. Those referable to the kidney itself (changes in the urine, pain, etc.). 2. Those referable to the gastrointestinal canal. 3. Those referable to the nervous system. In various cases one of these groups is more prominent than in others, sometimes one group is present to the exclusion, apparently, of others, while in some, two, or even all three groups are represented. It seems to be the nervous system group which is commonest in women.

Dr. Hanson: A matter worthy of study and one capable of demonstration, is why there are so many who have floating kidney, and yet have no symptoms during life? It is a well known fact that many women, particularly old women, come to autopsy with a movable kidney, and yet during their lives have had no symptoms referable to it. To me it seems a more interesting problem than the one as to how the symptoms really present in a case of movable kidney, may be explained.

Dr. Rixford: There certainly was no calculus present. We did not feel any, and yet I am sorry to say that we could not make out just what the nature of the obstruction was, nor its exact place; because, as I have said, the moment we lifted the kidney up, the urine dilated the ureter and ran from the catheter. Of course the symptoms resulting from obstruction of one ureter depend upon whether the case is acute or chronic and also very much on the condition of the other kidney. In chronic obstruction there is time for the opposite kidney to take on compensatory hypertrophy. A special illustration of the occurrence of the uremia from obstruction (acute) of one ureter, the other kidney being normal comes to mind just at present. A man of immense weight, something over three hundred pounds, suffered intensely from a renal colic which came on suddenly. I saw him 40 hours after the onset, after the first pain. He was not only unconscious, but deeply uremic. He was in extremis being practically pulseless. Operation was out of the question. We performed venesection taking away about a pint of blood. This seemed to improve him slightly, at least he became conscious and rational, but in a short time he grew rapidly worse and died. This makes, from the time of the onset of the first symptoms until death occurred, 42 hours. At the autopsy we found a stone impacted about the middle of the left ureter. The other kidney was normal as shown by microscopical examination. This is an illustration of what serious results and how even death may accompany the blocking up of one ureter, while the other kidney is normal.

Regular Meeting, Oct. 5, 1900.

Dr. C. N. Ellinwood in the chair.

FOREIGN BODY IN THE EYE—REMOVED BY A LARGE ELECTRO-MAGNET.

Dr. Barkan: Patient came about 12 days ago, stating that a chip of steel had struck him in the eye, two hours before his visit. Upon external examination no trace of the steel could be found, the lid and the eyeball seemed normal, except for a wound in the cornea a little to the outside of the pupil. The vitrious was oozing from the wound. Of course there could be but one conclusion, and that was that the foreign body had penetrated and lay in the interior of the eye. The pupil was enlarged by atropine, and on opthalmoscopic examination a large, irregular metallic body was seen lying in the bottom of the eye, about half way between the lens and the retina. My plan was first to enlarge the wound. This was done by a pair of straight scissors; then Haab's large magnet was placed with its pole about one-third of an inch in front of the eye. The current was turned on and the magnet began pulling upon the steel, the patient, as all patients do the moment that this pulling begins, jumped backwards, and the metal having been moved forwards, became fastened in the wound. The incision was then enlarged to about one-third of an inch, and on again approaching the magnet and turning on the current, so firmly was the metal fixed in the wound because of its large size, that the magnet seemed to be pulling the eye outwards. After two trials, at any rate, the metal slipped through the opening and clung to the pole of the magnet. The wound was carefully cleansed, no suture was placed and the eye was bandaged. For the first 48 hours there was some pain. There was no infection. Recovery was very quick. It is now 12 days after the injury, and the vitrious is clear of hemorrhage. The pupil is still enlarged; the lens is clear, and vision is 20/30. I regard this as an exceptional demonstration of the great service which is done by the large electro-magnet.

AMEBIC DYSENTERY—COLOSTOMY—RECOVERY.

Dr. W. N. Sullivan: The patient, a man, aged 35, in December, 1898, enlisted in the Volunteer Army, and the attack of illness came on soon after his arrival in Manila. It began with a slight diarrhea, irregular, but exhausting enough to incapacitate him for duty. In February, 1899, he entered the Manila Hospital, where he was treated by internal medication, in conjunction with rectal irrigation of nitrate of silver solution. The improvement was not satisfactory, in fact there was practically none, and he was sent home to San Francisco. In May, 1899, he entered the Presidio Hospital at San Francisco, still suffering with the diarrhea. From July until October, 1899, he was in the Presidio Hospital, and he was treated there with all sorts of internal medication, and rectal injections, meanwhile steadily becoming worse. I saw him April 4, 1900; he was at that time suffering from an extreme pain in the abdomen, and still with the dysenteric discharges from 8 to 20 each day. He was extremely emaciated, and very weak physically, could barely drag himself around. He could eat no meat. Every indulgence in animal food was followed by an increase in the number of stools per day. These passages showed upon examination to be composed of water, mucus, pus and blood. At first the sulpho-carbolates were used as an injecting fluid, but these caused pain in the ascending colon and in the cecum. These irrigations did no good, although persisted in steadily, for a number of weeks. The patient grew gradually and steadily worse. On April 25th, acting upon the suggestion of Dr. Henry Barbat, of this city a colostomy was performed. This was proposed for two reasons, first to rest the bowels, and secondly that direct medication might be applied to the ulcerated surfaces. Accordingly, on April 25, 1900, an incision was made into the abdomen and the colon was sutured to the abdominal wall. Five days later the bowel was incised, and the colon was irrigated with a weak hydrogen-peroxid solution. These irrigations were kept up daily, for some time. Four months after the first opening into the bowel the wound finally closed. Two days after the colostomy was done, the temperature became normal, and appetite returned. Within a week the amebae disappeared from the stools. The patient is now practically well. He looks stout and well nourished.

Dr. Barbat: The report of the case given by Dr Sullivan leaves very little more to be added; however I must say, that before the operation the patient was very badly off. He was very badly emaciated, very weak; in fact it seemed as if there was nothing but death before him. The reasons for the colostomy were simple: first, that we might be able to treat the bowel thoroughly and directly; secondly, in fact the principal reason that we might give the intestinal ulcers surgical rest. Peristalsis does not allow of this rest, and colostomy meant prevention of the fecal matter from flowing over the surface of the ulcers. The amebae coli were not found after the first week. The striking thing clinically was the instantaneous relief from pain. The fecal matter coming out of the colostomy wound prevented irritation of the ulcerated surfaces, and the pain practically ceased. Of course it would have been better, if this work had been done early. In the light of the teaching of this case, I believe it would have been far better to have done the work, and the work in all such cases very much earlier, rather than to let them go and go along as we did.

Dr. Hirschfelder: I have seen but two cases on this Coast. Both of them recovered so far as I know. The first one I treated at the City and County Hospital with the old time quinine injections. These simply relieved the symptoms, and the patient left the Hospital, and what became of him I do not know. The second case was in a Japanese, the quinine was tried here, but it had absolutely no effect. Sulphureted hydrogen injections were then tried, and one morning when we were giving these, the Jap collapsed, I thought he was surely dying, but he did not. He recovered finally, enough to leave the Hospital.

Dr. Stillman: I have seen several cases of amebic dysentery, and they were all in returning soldiers from the Philippines. We will have more of these cases. What we need is a bibliography of the work done in the direction indicated by the author of this paper.

Dr. Lane: I think Dr. Sullivan and Dr. Barbat are entitled to great praise and credit for the work which they have done, and the success which they have attained in the treatment of this case, one of the most disappointing that we have to deal with in medicine.

Dr. Hanson: Sternberg states, in one of his works, that in the Naples epidemic of dysentery, only about one in twenty of the cases, as shown by statistics, was caused by the ameba coli. A number of other epidemics were investigated with the same object, and this same ratio was found to be true.

Dr. Sullivan: I have found five references of this kind of work, but they were difficult to obtain, and I could not look them up. I am sure that the operation has been done a number of times before. At present these cases either die in the Philippine Islands, or recover before coming to this country. Some of them are in extremely bad condition. One case was reported to me of a man who was reduced simply to skin and bone; he weighed only 45 pounds.

TRICHINOSIS.

Dr. Hirschfelder: Maurice Greton, aged 46, single, native of Switzerland, occupation dish-washer, was admitted September 12, 1900. Family history negative. Patient states that as a child, he was always sick, but he does not know with what disease. The only sickness he has had since childhood was malaria in New Orleans two and one-half years ago. Patient uses alcohol and tobacco to excess. Denies all venereal history. On August 24, 1900, patient went to Baden, where he worked at the slaughter-house, throwing bones into a vat; while working in the steam chamber, patient perspired freely, and had frequent attacks of pain in the stomach, headache and felt oppressed; but these passed off, on leaving the chamber. While at Baden his appetite was excellent. Patient states that every day for dinner, he ate pork chops or bacon, and they were usually rare; he likewise often ate pork for supper. Patient took meals at the Armour Hotel; patient remained at Baden 15 days. On September 5th patient left Baden and walked to San Francisco, a distance of twelve miles; fifteen days previously had walked to Baden in a few hours with little discomfort; on walking back became greatly fatigued, and had to rest often. On September 7th went to Livermore; for a day before this he had not been feeling well, and was tired and suffered from a severe headache. Returned from Livermore on September 9th, and worked as dishwasher in the hotel, 401 Pacific Street, this city. On night of September 9th was given a powder for headache, which he thinks was given to drug him; went to bed after taking powder, and drank two bottles of wine; patient states that he lost consciousness for some time. The medicine, which he took, purged him freely, has sweats every day since he became ill, but does not know whether or not he has had any chills, has had severe pain in head, over temple, and at the base; also pain in the epigastrium, localized to left of ensiform appendix. Patient has difficulty and pain on urination, and passes more urine than formerly. September 13th, Widal reaction negative; urine specific gravity 1.021, 15.43 cubic centimeters, amber color, heavy sediment, acid reaction, no sugar, no albumen, no diazo-reaction, but a trace of indican. Temperature 104.5°. September 14, examination: the patient a well nourished individual, no peculiarities of head, left pupil slightly larger than right, both react to light. Both lower lids puffy; small vesicles on nose, about one millimeter in diameter, containing clear fluid; a deposit of thrush found on the gums. The vesicles were soudaminal. The tongue slightly coated with white coating; movements of head normal; glands of neck slightly enlarged; cubital glands not enlarged; thorax short, broad, well arched and deep; no dullness of lung; respiratory murmur vesicular; heart tones clear, but feeble, pulse feeble, abdomen not distended but slightly sensitive. Liver dullness 11½ centimeters; not palpable, on account of tension of abdomen; Kernig's symptom absent; spleen at the posterior axillary line; blood examination, no eosinophiles found, as was determined later on account of poor stain; urine 1.023 acid, no albumen, no sugar, no diazo reaction, indican present, milk diet ordered. September 15th: patient delirious last night, no pain in the head this morning; left pupil slightly larger than right; liver dullness 12½ centimeters; puffiness of eyelid decidedly less; mind clear. September 17th: Patient had to be strapped in bed, last night, was delirious, temperature 104.8°; this morning temperature 101.7°; patient sweating profusely; left pupil still larger than the right; both react to light; tongue was covered with a thin white coat; thrush upon gums still present; pulse 80; respiration 24; patient rises in bed without difficulty; no dullness of lung; respiratory movement equal; murmur vesicular; abdomen flat; few roseola spots seen upon the abdomen, in addition to numerous acne eruption; the entire abdomen sensitive to pressure; no ileocecal gurgling; spleen four centimeters from anterior axillary line; four centimeters from edge of the rib; Kernig's symptom absent; knee jerk absent; urine 1.020; indican and diazo-reaction present; no albumen. September 18th: Muscles of entire body sensitive to pressure; temperature 102.5°. September 19th: The temperature 102.9°; appearance of face somewhat grayish; sweats profusely; left pupil still larger than right; tongue coated with thick white coating; swelling of lids less marked; muscles and nerves over whole body sensitive. September 20: Pieces of muscles of the gastrocnemius shows trichinae. September 21st: Blood count—red, 5,200,000; white, 11,000; eosinophiles, 24%; small, 20%; large, 7%; polynuclear, 49%. September 22d: Patient better; urine 1.029; no albumen; no indican; marked diazo-reaction; enema given, but show no trichinae; temperature 29°. September 23d: Temperature 98.5°; patient better. September 24th: Urine; no albumen; no diazo-reaction; no indican; blood count—polynuclear, 39%; large, 6%; small, 22%; eosinophiles, 33%. September 25th: Urine negative; patient much better; muscles still sensitive. September 26th: Patient improving; muscles slightly sensitive; patient clear in mind. Convalescense steady from this day onward.

CORRESPONDENCE.

San Francisco, Cal.,
December 1, 1900.
......................., M. D.

Dear Doctor:—The Medical Society of the State of California at the Fresno meeting, 1898, and later, at the Del Monte meeting in 1899, appointed a special committee on medical legislation, of which committee I have the honor to be Chairman. The purpose of this committee is to frame and have passed by the State Legislature a new medical law—one which will be more effective than our present worthless statute. This committee has very thoroughly canvassed the subject of the medical laws of most of the States of the Union and have finally formulated one which is to be introduced at the next session of the Legislature.

This law, as drafted, has been submitted to most of the leading men of our school in this city, to the leading men of the homeopathic and eclectic schools. Separately, and in joint convention, all have agreed that it will be satisfactory in effect and fair to all. All schools will join us in our effort to pass it. It provides for a single examining board of nine members—five elected by the Medical Society of the State of California; two, by the California State Homeopathic Society; two by the Eclectic Medical Society of the State of California. Six members to constitute a quorum. Applicant must present diploma, letters and submit to an examination by the board. Such examination to be practical, not technical,—each school examining its own applicants in materia medica and therapeutics.

The proposed new law shall, in no respect, affect physicians holding certificates under the present law.

Will you, to assist this committee, make a special effort to personally see, or communicate with the State Senator and Representatives from your county and others whom you may be able to reach, and explain to them the purpose and object of this movement and solicit their support for the bill when it shall be presented at Sacramento. You are to understand that this matter has the sanction of the Medical Society of the State of California, which society has authorized it, and that the other societies are in accord with it.

I will be pleased to furnish you with any information upon the subject which you may desire. Trusting that you will give the matter your personal attention, I remain,

Yours very truly,
F. B. Carpenter, M. D.,
No. 803 Sutter Street.

BOOK REVIEWS.

Medical Analects.

This little volumne presented by the California Pharmacal Company is, as it purports to be, a valuable guide, and if employed of constant benefit. It gives more than any other of booklets arranged on similar lines, and all its notices on their preparation are modestly given and presented with perfect propriety, not occupying all the best space as in many like works. The prescriptions offered are those in use by some of the foremost physicians here and elsewhere and are worthy of trial.

The dosage table and classification tables are full accurate and evidence special care in their preparation. The book is in vest-pocket form, neatly printed and bound, and is worthy perusal and use.

This book is on sale at the Emporium Book Store.

MEDICAL ITEMS.

Dr. Alfred E. Regensburger having returned from his European trip, has resumed the practice of his profession at No. 14 Grant Avenue.

Dr. Vard H. Hulen has removed his office to 135 Geary Street, Spring Valley Building.

Dr. Douglass W. Montgomery has moved his office and residence to 1301 Van Ness Avenue, corner of Sutter Street.

Dr. George B. Somers has returned and resumed practice. Office in Press Club Building, San Francisco. Hours 3:30 to 5 p. m. Tel. Bush 315.

Dr. George Preston Wintermute begs to announce his return from Europe. Offices, rooms 60-62 Spring Valley Building, corner Geary and Stockton streets, San Francisco. Hours, 2 to 5 p. m.

LICENSES GRANTED.

5687. Beattie, William George, San Francisco
5688. Besson, Edward Aubert, San Francisco.
5689. Booth, Joel Clarence, San Francisco.
5690. Buell, William Eugene, San Francisco.
5691. Burks, W. T., Fresno.
5692. Coney, Elmer J., Fresno.
5693. Crook, Anne Lawson, San Francisco.
5694. Dodsworth, Robert Metcalf, Azusa.
5695. Hill, James David, San Francisco.
5696. Huntington, Ralph Addison, San Francisco.
5697. Kirk, Albert W., San Francisco.
5698. Knowles, Calvin W., San Francisco.
5699. Laist, Otto, San Francisco.
5700. Lewis, Arthur Parker, San Francisco.
5701. Mallory, George Washington, San Francisco.
5702. Piersol, Frank Clayton, San Francisco.
5703. Peters, William, San Francisco.
5704. Plymire, Harry Garritson, San Francisco.
5705. Satterlee, Frank P., Dean, Nev.
5706. Spriggs, Gertrude Anna, San Francisco.

5707. Troppmann, Charles Martin, San Francisco.

5708. Veale, Almer Fletcher, San Francisco.

5709. Wahl, Hugo A., San Francisco.

5710. Williams, Benjamin Francis, San Francisco.

5711. Wood, Eugene G., Oakland.

5712. Zachariah, Simon R., San Francisco.

5713 Abbot, Clark Lorenzo, San Francisco, Rush Medical College, Chicago Ill., June 21, 1900.

5714. Betts, William W., Los Angeles, Albany Medical Colege, N. Y., March 9, 1883.

5715. Bennett, Charles Edward, Wanscon, O., Detroit Medical Colege, Mich., Feb. 29, 1875.

5716. Cox, Frederick Warren, San Francisco, Bellevue Hos. Med. Coll., New York, March 14, 1887.

5717. Downes, Charles Sheridan, San Francisco, Coll. Phys. & Surg., S. F., Cal., July 5, 1900.

5718. Droll, George Amos, Oakland, Cooper Medical College, Cal., June 5, 1900.

5719. Evans, John Hedley, Highland, Kansas City Med. Coll., Mo., March 15, 1900.

5720. Ewing, William Brown, Pittsburg, Rush Medical College, Ill., Feb. 17, 1885.

5721. Goodall, Ellis Leon, Rowe, Med. Dept. Columbian Univ. Wash., D. C., May 6, 1897.

5722. Haas, Agustin, San Francisco, Univ. of Guttingen, Germany, June 27, 1885; Bd. of Public Instruction, City of Mexico, March 17, 1888.

5723. Hammond, Henry Powers, Berkeley, Albany Medical College, N. Y., May 19, 1899.

5724. Harris, Henry, Baltimore, Md., Johns Hopkins Univ., Baltimore, Md., June 13, 1899.

5725. Heffernan, William T., Los Angeles, Ohio Med. Coll., Cincinnatti, O., March 7, 1889.

5726. Key, Morris Howard, Chicago, Long Island Med. Coll., N. Y., May 16, 1899.

5727. Lanz, Paul Ruhuke, San Francisco, Med. Dept. Univ. of California, May 16, 1899.

5728. Longstreet, Arthur Hubert, New York, Med. Dept. Univ. of Vermont, June 28, 1900.

5729. MacDonald, Everett Anderson, Dayton, O., Medical College of Ohio, April 4, 1895.

5730. Maclean, Neil John, Winnepeg, Can., University of Manitoba, Canada, June 3, 1898.

5731. MacFarlane, Nowland, San Bernardino, Beaumont Hos. Med. Coll., Mo., March 30, 1900.

5732. Martin, John Henry, Los Angeles, Baltimore Med. Coll., Maryland, March 23, 1899.

5733. McElroy, Bernard Francis, Oakland, Med. Dept. Univ. of California, May 16, 1899.

5734. Miyabe, Tadataro, San Francisco, Med. Dept. Univ. of Califirnia, May15, 1900.

5735. Moore, William George, San Francisco, Med. Dept. Univ. of California, May 15, 1900.

5736. Nusbaumer, Pauline Schueer, Pleasanton, Women's Med. Coll. of Pennsylvania, Pa., May 16, 1900.

5737. Plath, O. E., Phoenix, Ar., Miama Medical College, Ohio, April 3, 1896.

5738. Sommer, Ernst August, Oregon City, Med. Dept. Williamette Univ., Or., April 7, 1900.

5739. Smith, Dudley Almonte, Santa Barbara, Jefferson Medical College, Pa., May 15, 1900.

5740. Smith, Rensssclarr, J., Los Gatos, Med. Dept. Univ. City of New York, March 11, 1884.

5741. Van Strander, William Harold, Hartford, Conn., Med. Dept. Univ. of Vermont, June 28, 1900.

5742. Sullivan, John Francis, San Francisco, Med. Dept. Univ. of California, May 15, 1900.

5743. St. Sure, Frank Augustus, Alameda, Coll. Phys. & Surg., S. F., Cal., July 5, 1900.

5744. Takemura, Gakujiro, San Francisco, First High School, Chiba, Japan, Nov. 27, 1897.

5745. Westerfeld, Otto Ferdinand, San Francisco, Cooper Medical College, Cal., June 5, 1900.

5746. Wood, Frank Lyon, Orange, Med. Dept. Harvard Univ., Mass., June 27, 1900.

5747. Bacon, David Nelson, Pasadena, U. S. Grant Univ., Tennesee, March 15, 1892.

5748. Bolz, Charles, Petaluma, Albany Med. Coll., N. Y., March 7, 1883.

5749. Briggs, Evelyn, Sacramento, Johns Hopkins Univ., Md., June 12, 1900.

5750. Carroll, William Lawther, Toronto, Ohio, Baltimore Med. Coll., Md., April 7, 1894.

5751. Cunningham, Charles McDowell, San Francisco, Cooper Med. Coll., Cal., June 5, 1900.

5752. Deaton, Ulysses Sim. Grant, Thackery, Ohio, Memphis Hos. Med. Coll., Tenn., March, 1894.

5753. Duffield, William, Phœnix, A. T., Med. Dept. Univ. of Pennsylvania, May 10, 1893.

5754. Ehrlick, Benj. Praskar, San Jose, Med. Dept. Univ. of Pennsylvania, June 13, 1900.

5755. Gambatto, Carlo Antonio, San Francisco, Univ. of Genoa, Italy, July 28, 1883.

5756. Gingles, Rush A., Seattle, Wash., Louisville Med. Coll., Ky., March 2, 1893.

5757. Hanlon, Edward Russell, San Francisco, Cooper Med. Coll., Cal., August 22, 1899.

5758. Harvey, William P., San Francisco, Med. Dept. Uhiv. of California, May 15, 1900.

5759. Jerould, Frederick N. C., Niagara Falls, N. Y., Med. Dept. Univ. City of New York, April 7, 1893.

5760. Koons, H. Haynes, Los Angeles, Med. Dept. Univ. of Pennsylvania, June 9, 1897.

Chas. C. Wadsworth, M. D.,
Secretary.

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OCCIDENTAL MEDICAL TIMES

COMBINING THE

"Pacific Record of Medicine and Surgery" and the "Occidental Medical Times."

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JAMES H. PARKINSON, Sacramento.

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